Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 31, 2018; | 2018_703625_0014 (A2) | 007447-18, 011226-18 | Complaint |

### Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

Ontario

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**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

Amended by MICHELLE BERARDI (679) - (A2)

## Amended Inspection Summary/Résumé de l'inspection modifié

**An amendment has been granted to allow the Licensee to achieve management stability.**

**Issued on this 31 day of October 2018 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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550 Osborne Street FORT FRANCES ON P9A 3T2

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

Amended by MICHELLE BERARDI (679) - (A2)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): June 20, 21 and 22, 2018.**

**This Complaint inspection was conducted to inspect on:**

**- log #007447-18 regarding the plan of care and care provided to a resident; and**

**- log #011226-18 related to resident finances.**

**Critical Incident System (CIS) inspection #2018_703625_0013 was conducted concurrently with this Complaint inspection.**

**This inspection was also conducted by Inspectors Julie Kuoriskoski (#621), Abby Wizman (#713) and Angie Ng-Evans (#718).**

**During the course of the inspection, the inspector(s) spoke with residents, RPNs, RNs, an Activation Worker, a Financial Service employee, the Director of Finances, the Financial and Statistical Analyst, the Administrative Assistant, the Receptionist, the Registered Dietitian (RD), the Food Services Supervisor (FSS), the Director of Care (DOC) and the Administrator.**

**The Inspectors also conducted daily tours of resident care areas and observed the provision of care and services to residents. The Inspectors reviewed residents' health care records, residents' financial files, the home's Resident Trust Account policy, annual trust account audits, trust account statements and financial reports and email correspondence.**

**The following Inspection Protocols were used during this inspection:**

**Hospitalization and Change in Condition**

**Resident Charges**

**Trust Accounts**

**During the course of the original inspection, Non-Compliances were issued.**

- **5 WN(s)**
- **3 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was in compliance with all applicable requirements under the Act.

Ontario Regulation 79/10, s. 241 (5) identifies that every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed the licensee’s policy titled “Resident Trust Accounts – ORG-I-FIN-10”, effective April 26, 2018. The policy identified that where the licensee administered the resident’s income, funds in excess of the maintenance costs would be deposited as per the resident’s request, in the resident’s personal account or the trust account.

The policy was not in compliance with legislation as it identified that the licensee may administer the resident’s income.

Ontario Regulation 79/10, s. 241 (12) indicates that a licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, should not receive, hold or administer the property of a resident in trust other than as provided for in this section.

Ontario Regulation 79/10, s. 242 (6) indicates that, for greater clarity, municipalities that were holding and administering the real or personal property of a resident pursuant to an agreement approved by the Director under section 11 of the Homes for the Aged and Rest Homes Act, other than funds held in a trust account, could continue to hold that property for no more than six months after the coming into force of this section [July 1, 2010].

During an interview with the Director of Finance, they stated that this specific section of the Resident Trust Accounts policy referred to the licensee's processing of government issued cheques for multiple residents in the home, which the licensee deposited into the residents' trust accounts from which they paid the residents' accommodation charges, referred to in the policy as "maintenance

costs". The Director of Finance identified that the residents did not have any one to act on their behalf to have the money deposited elsewhere, or to pay their accommodation fee in any other way.

In addition, the policy was not in compliance with legislation as it indicated that the resident could be charged "maintenance costs" which would be deducted from the money deposited into the resident's trust account by the licensee.

Ontario Regulation 79/10, s. 241 (4) (c) indicates that no licensee shall charge a resident, or a person acting on behalf of a resident, a transaction fee for withdrawals, deposits, or anything else related to money held in trust. [s. 8. (1) (a)]

2. The licensee has failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10, s. 241 (5) identifies that every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed the home’s policy titled “Resident Trust Accounts – ORG-I-FIN-10”, effective April 26, 2018. The policy identified that:

(a) The licensee must provide the resident, or person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any person, for deposit in the trust fund on behalf of the resident.

The licensee's Resident Trust Accounts policy was not complied with as written receipts had not been provided to residents, or any other person, for all deposits made into trust accounts on behalf of the resident.

During an interview with Financial Services employee #103, they stated that they did not provide written receipts for deposits to resident trust accounts made by cheque and received through the mail.

(b) Verbal authorization was not acceptable if a resident, or a person acting on

behalf of a resident (who had legal authority to manage the resident's property), wished to pay for charges with money from a trust account.

The licensee's Resident Trust Accounts policy was not complied with as verbal authorization had been accepted for recreational activity charges from residents' trust accounts.

During reviews of Resident Ledger Trust Account Detail Reports and Purchase of Services agreements for residents #013 and #004, it was identified that they were charged for for specific items without written authorization.

During an interview with Activity Assistant #105, they stated that they obtained verbal consent for residents to participate in recreational activities at times, when they spoke to family in passing, which included obtaining money from the residents' trust accounts for the residents to participate in the activities.

(c) Financial staff (designated Financial and Statistical Analyst) were to review reports daily and ensure they balanced with the trust ledger.

The licensee's Resident Trust Accounts policy was not complied with as the review of identified reports was completed less than daily.

During an interview with Receptionist #102, they stated that they did not provide the Financial and Statistical Analyst with the reports referred to in the policy for daily review, but rather provided the reports to the analyst at a lesser frequency.

(d) Any withdrawal request greater than $100.00 would be issued by cheque or authorized, in writing, by the Long Term Care Home or Eldcap facility Administrator and the resident or any person acting on behalf of the resident (who had legal authority to manage the resident’s property).

The licensee's Resident Trust Account policy was not complied with as withdrawal requests greater than $100.00 had not been issued by cheque or authorized in writing by the home's Administrator.

Resident #007’s Resident Ledger Trust Detail Report identified a personal withdrawal of greater than $100.00 on a date in the spring of 2018.

During an interview with resident #007, they stated they had withdrawn in excess

of $100.00 for a particular purpose.

During an interview with the Administrator, they stated that, although the licensee’s Resident Trust Accounts policy, effective April 26, 2018, indicated they were required to provide written authorization for withdrawals greater than $100.00, they had not provided this written authorization to date.

(e) Detailed trust statements were to be prepared by the Financial and Statistical Analyst. Statements would be printed and distributed when the trust account balance was zero or the account was in arrears. For an overdrawn account, all preauthorized transactions and withdrawal requests would cease immediately.

The licensee's Resident Trust Accounts policy was not complied with as preauthorized transactions and withdrawal requests had not immediately ceased when residents' trust account balances were zero or the accounts were in arrears.

A review of resident #007’s Resident Ledger Trust Detail Report with a focus on the date the policy came into effect, April 26, 2018, identified that the resident made personal withdrawals and had charges withdrawn from the account despite the balance being negative. A personal withdrawal made by the resident, on a date in the spring of 2018, put the resident’s trust account into a negative balance, after which multiple charges and another personal withdrawal occurred, further putting the trust account balance into arrears.

During an interview with Receptionist #102, they stated that resident #007 had withdrawn money in the spring of 2018 that put their trust account into a negative balance. The Receptionist stated they continued to provide resident #007 with money when their account had a negative balance. The Receptionist also stated they were required to process cheques for incurred costs whether or not the resident's trust account balance was zero or in arrears.

(f) The management and administration of residents’ funds is governed by the provision of the Ministry of Health and Long-Term Care and the Long-Term Care Homes Act, 2007.

The licensee's Resident Trust Accounts policy was not complied with as the management and administration of residents' funds was not governed by the provisions of the LTCHA, as the home failed to establish and maintain a trust account for convalescent care residents.

The Long-Term Care Homes Act, 2007, c. 8, s. 183 (2) (o) identifies that, without restricting the generality of subsection (1), the Lieutenant Governor in Council may make regulations requiring licensees to establish trust accounts for residents, and governing the administration of the trust accounts.

Ontario Regulation 79/10, s. 241 (1) identifies that every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee’s care on behalf of a resident. The legislation does not exclude convalescent care residents from depositing money into a trust account.

The home was not able to provide Inspector #625 with a financial file for former convalescent care resident #017.

During an interview with the Administrator, they stated that resident #017 did not have a financial file containing financial documents as the accommodation fee for the convalescent care resident was funded and not paid by the resident. With respect to the other financial agreements in place for long term residents in the home [specifically the Purchase of Services Agreement], the Administrator stated there were no agreements in place for convalescent care residents.

During an interview with the Director of Finance, they stated that the licensee did not offer trust accounts to convalescent care residents as it was too hard to manage if they only resided in the home for three months. The Director also stated that they did not enter into Purchase of Services agreements with the convalescent care residents, as the licensee only offered convalescent care residents phone and TV services, which would not be paid from a resident trust account as the convalescent care residents would not have one in place.

(g) The resident or any person acting on behalf of the resident (who has legal authority to manage the resident’s property), was required to provide written authorization to the licensee for all preauthorized personal withdrawals from the resident’s trust account. The Service Agreement defined all preauthorized withdrawals and/or charges.

The licensee's Resident Trust Accounts policy was not complied with as the home permitted a person, who did not have legal authority to manage a resident’s property, to enter into a written agreement with the licensee preauthorizing

personal withdrawals from the resident's trust account as detailed in their signed Purchase of Service Agreement.

A review of resident #019's financial file identified that the resident signed their own Accommodation Agreement on  a date in the summer of 2017, while the resident's family member #116 signed the resident's Purchase of Services Agreement and accompanying Form A Resident Charges and Trust Account Authorization on the same date. Family member #116 signed in the area designated for the resident's "Power of Attorney for Property/Guardian/Trustee".

A faxed document provided by the Director of Finance identified that resident #019 had the legal authority to manage their own finances from the date of their admission.

During an interview with resident #019, they were able to accurately recall details related to their admission and time in the home, and that family member #116 had signed admission papers.

During an interview with the Financial and Statistical Analyst, they stated that resident #019's accommodation statements were sent to the resident while their trust account statements were sent to the resident's other family member #117, but that resident #019 was legally responsible for their own accommodation and trust accounts. They identified that the resident would be legally responsible for their accommodation and trust accounts and, as per their admission agreements, that the resident had the legal authority to enter into a legal contract with the home, not family member #116.

During an interview with the Administrator they stated that, on admission, the home determined who was able to sign the admission documents if they were the resident, the substitute decision-maker, had power of attorney or were the Office of the Public Guardian and Trustee. The Administrator stated that another person could not enter into a legal agreement with the home on behalf of a resident if the resident was still capable. [s. 8. (1) (b)]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)The following order(s) have been amended:CO# 001**

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts**

**Specifically failed to comply with the following:**

**s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).**

**s. 241. (4) No licensee shall,**
**(a) hold more than $5,000 in a trust account for any resident at any time; O. Reg. 79/10, s. 241 (4).**
**(b) commingle resident funds held in trust with any other funds held by the licensee; or O. Reg. 79/10, s. 241 (4).**
**(c) charge a resident, or a person acting on behalf of a resident, a transaction fee for withdrawals, deposits, or anything else related to money held in trust. O. Reg. 79/10, s. 241 (4).**

**s. 241. (5) Every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,**
**(a) a system to record the written authorizations required under subsection (8); and O. Reg. 79/10, s. 241 (5).**
**(b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money. O. Reg. 79/10, s. 241 (5).**

**s. 241. (7) The licensee shall,**

**(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; O. Reg. 79/10, s. 241 (7).**

**s. 241. (7) The licensee shall,**
**(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).**

**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).**

**s. 241. (12) A licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, shall not receive, hold or administer the property of a resident in trust other than as provided for in this section. O. Reg. 79/10, s. 241 (12).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that at least one non-interest bearing trust account was established and maintained at a financial institution in which the licensee deposited all money entrusted to the licensee's care on behalf of a resident.

The home was not able to provide Inspector #625 with a financial file for former convalescent care resident #017.

During an interview with the Administrator, they stated that resident #017 did not have a financial file containing financial documents as the accommodation fee for the convalescent care resident was funded and not paid by the resident. With respect to the other financial agreements in place for long term residents in the

home [specifically the Purchase of Services Agreement], the Administrator stated there were no agreements in place for convalescent care residents.

During an interview with the Director of Finance, they stated that the licensee did not offer trust accounts to convalescent care residents as it was too hard to manage if they only resided in the home for three months. The Director also stated that they did not enter into Purchase of Services agreements with the convalescent care residents, as the licensee only offered convalescent care residents phone and TV services, which would not be paid from a resident trust account as the convalescent care residents would not have one in place. [s. 241. (1)]

2. The licensee has failed to ensure that no more than $5,000 was held in a trust account for any resident at any time.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed 2017 and 2018 Resident Ledger Trust Detail Reports and identified that residents #003, #004 and #005's trust accounts held more than $5,000 in the non-interest bearing accounts.

The licensee's policy titled "Resident Trust Accounts - ORG-I-FIN-10", effective April 26, 2018, identified "A resident's trust account can never exceed $5,000 at any time".

Inspector #625 reviewed a fax provided by the Director of Finances which identified, in 2017 and 2018, the home's Financial Officer and Administrators had held the positions of trustees for residents #004 and #005's finances, when their trust account balances had been in excess of $5,000.

During an interview with Receptionist #102, they stated that they did not verify how much money residents had in their trust accounts before accepting cheques on their behalf. The Receptionist stated they did accept cheques that would put a trust account balances in excess of $5,000.

During an interview with Financial Services employee #103, they stated that they had been aware that some residents had in excess of $5,000 in their trust accounts.

During an interview with the Financial and Statistical Analyst, they confirmed that

residents #003 and #004 had greater than $5,000 in their trust accounts.

During an interview with the Administrator, they stated that they had been aware that resident #003 had greater $5,000 in their trust account and the home had worked on reducing the account to less than $5,000. They reviewed the trust account ledger and confirmed that the resident continued to have greater than $5,000 in their trust account, and that resident #004 had greater than $5,000 in their trust account. [s. 241. (4) (a)]

3. The licensee has failed to establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed the home's policy titled "Resident Trust Accounts – ORG-I-FIN-10", effective date April 26, 2018. The policy did not identify that earlier versions of the policy had been in place.

During an interview with Financial Services employee #103, they stated that they were not sure whether there had been a previous policy on the management of trust accounts or not.

During an interview with the home's Administrator, they stated that they could not locate a policy in place prior to the current trust account policy effective April 26, 2018.

During an interview with the Financial and Statistical Analyst, they stated they were not aware of a trust account policy in place prior to the current policy effective April 26, 2018, but acknowledged that a written trust account policy was required as per legislation.

During an interview with the Director of Finance, they stated that there had not been a policy on the management of resident trust accounts in place prior to the current policy which took effect April 26, 2018. [s. 241. (5)]

4. The licensee has failed to provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident.

A complaint was submitted to the Director related to resident finances in the home.

During an interview with resident #006, they stated that they wrote cheques to deposit money into their trust account in the home.

During an interview with resident #007, they stated that they deposited money into the trust account by writing a cheque from their bank account.

A review of resident #006’s Resident Ledger Trust Detail Report identified that a cheque for a particular amount of money was deposited in to the resident’s trust account on a date in the spring of 2018.

A review of resident #007’s Resident Ledger Trust Detail Report identified that cheques were for specific amounts of money were deposited, into the resident's trust account, on multiple dates in the winter and spring of 2018.

The Inspector reviewed the licensee's policy titled "Resident Trust Accounts - ORG-I-FIN-10", effective April 26, 2018, which identified the licensee was required to provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in the trust fund on behalf of the resident.

Inspector #625 reviewed copies of receipts provided to residents by Receptionist #102 for cash and cheque deposits into trust accounts and could not locate corresponding copies of receipts for the identified deposits made into resident #006’s or #007’s trust account.

During an interview with Receptionist #102, they stated that resident #007 deposited money into their trust account by cheque. They were not able to locate a corresponding written receipt for the money deposited into resident #007’s trust account on dates in the winter and spring of 2018.

During an interview with Financial Services employee #103, they stated that they processed resident cheques for deposit into resident trust accounts. The Financial Services employee stated that they did not provide written receipts for the cheques that arrived at the home by mail. [s. 241. (7) (a)]

5. The licensee has failed to provide to the resident, or to a person acting on behalf

of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed resident #001's Resident Ledger Trust Detail Reports and identified the resident's trust account had a specific balance in 2017 and 2018.

Inspector #625 reviewed resident #001's financial file including a document dated the spring of 2018 which identified the resident had not managed their finances since being admitted to the home and there was no person who held Power of Attorney for Property and Personal care for the resident for a specific period of time.

During an interview with Financial Services employee #103, they acknowledged that the resident #001 had not had anyone authorized to manage property on their behalf for a particular length of time. The employee did not know who had received the resident's trust account statements during that time.

During an interview with Administrative Assistant #104, they stated they relied on Financial Services employee #103 to enter the residents' legal substitute decision-makers (SDMs) into GoldCare to allow them to generate a trust account statement addressed to the person legally responsible to manage the residents' property. The financial services employee stated that, during the period of time resident #001 had no one legally authorized to manage their property, the Administrative Assistant had sent resident #001's trust account statements directly to the resident on the unit on which they resided. They further commented that the home's practice prior to May 2017, was to file trust account statements for a number of residents in their financial files, without providing the resident or their SDM with a copy. They stated that in the spring of 2017, DOC #101 had directed them to provide every resident with a trust account statement and that, if the resident did not have a SDM in place, the DOC instructed the Administrative Assistant that the statements were to be given to the residents.

Inspector #625 reviewed an undated list provided by Administrative Assistant #104, which they stated contained the residents who had not had trust account statement provided to them or their SDM prior to the spring of 2017. The document listed residents #003, #004, #005, #008, #010 #011, #012, #013, #014, #015 and #016.

During an interview with the DOC, they stated that prior to the spring of 2017, trust account statements had not been provided to all residents in the home.

During an interview with the home's Administrator they stated that they did not believe anyone had the legal authority to manage resident #001's property for a period of time, and did not know who had received the resident's trust account statements during that time. The Administrator identified that resident trust account statements should have been provided to a SDM or the Office of the Public Guardian and Trustee (PGT), if a resident had not been capable of managing their own finances. [s. 241. (7) (f)]

6. The licensee has failed to ensure that a resident, or a person acting on behalf of a resident, who wished to pay a licensee for charges under section 91 of the Act with money from a trust account provided a written authorization that specified what the charge was for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed Form A Resident Charges & Trust Account Authorization included in the home's current admission package. The form identified that authorization for charges could be provided by the resident for tuck shop items, recreational events and outings, hair stylist and barber services, cable television, drugs not covered under Ontario Drug Benefit Plan (ODB), transportation, alcoholic beverages, advanced foot care and community support services. The form stated that the amount of charge or cost for each service was set out in the appendix to the form, and the resident should complete a new form if they wanted to change their trust account authorization.

The current corresponding Appendix to Form A: Price/Charge List identified tuck shop charges would "vary according to item and number of purchases", recreational events and outings "As per arrangement for each individual outing", cable television "$33.11 per month", drugs not covered under ODB "The amount of money the Home withdraws from the trust account will vary according to the number of filled prescriptions not covered by ODB", transportation "Handi van cost is $2.00 one-way", alcoholic beverages "each alcoholic drink is $2.00" and advanced foot care "As per arrangement with provider". The appendix identified "You may want to change your trust account authorization following a change in

price or charges. If so, you must complete a new authorization form, which the home will provide to you on request."

Neither document identified the amount of the charges for tuck shop items, recreational events and outings, or drugs not covered under ODB.

Inspector #625 reviewed resident #003's financial file including the Form A Resident Charges & Trust Account Authorization dated 2018. The form identified that authorization was provided by the resident's SDM for specific items. The form did not provide written authorization to the licensee for the amount of the charges authorized for these items.

The Inspector reviewed resident #001's financial file including their Purchase of Services Agreement dated 2011. The agreement did not authorize charges for specific items. The attached Appendix to Form A: Price/Change List listed cable television charges as $18.00 per month, transportation as $1.25 each way for the Handi van and a specific care charge as $25.00 per visit. Resident #001's 2017 Resident Ledger Trust Detail Report identified that the resident had been charged for items without written authorization in place.

Inspector #625 reviewed resident #007's Purchase of Services Agreement dated 2013, which included authorization for specific items. The Attached Appendix to Form A Price/Change List identified the cable television charge as $20.00, the Handi van as $1.25 one way and alcoholic drinks as $2.00 each. Resident's 2017 and 2018 Resident Ledger Trust Detail Reports listed charges that differed from the written authorized amounts and contained charges for items without written authorization.

During an interview with resident #007, they stated that specific items had been paid from their trust account, including one item they usually paid for in another manner. The resident stated they did not think the home should have paid for a particular item from their trust account and the home did not have their authorization to do so.

The Inspector reviewed resident #013's Purchase of Services Agreement dated 2014, and amended in 2015, which did not provide written authorization for charges for an item. The Appendix to Form A: Price/Change List identified cable television as $21.00 per month and Handi van transportation as $1.25 one way. The Resident Ledger Trust Detail Reports for 2017 and 2018 identified charges for

specific items and amounts. Resident #013 had been charged an amount that differed from the written authorized charge and for an item without written authorization.

The Inspector reviewed resident #004's Rainycrest Long Term Care Resident Admission Agreement which included a Schedule B Unfunded Services Authorization Form dated 2009. The form authorized the home to bill the resident one particular item, and identified "No" beside "Comfort Trust Account". The admission agreement did not authorize charges other specific items. Resident #004's Resident Ledger Trust Detail Reports for 2017 and 2018 included withdrawals from the resident's trust account for multiple items without written authorization.

The licensee's policy titled "Resident Trust Accounts - ORD-I-FIN-10", effective April 26, 2018, identified "A resident, or person acting on behalf of a resident (who has legal authority to manage the resident's property), who wishes to pay RCH for charges under section 91 of the LTCHA with money from a trust account shall provide RHC with a written authorization that indicates 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. Verbal authorization is not acceptable."

During an interview with Activity Assistant #105, they stated that they obtained verbal consent for residents to participate in recreational activities at times, when they spoke to family in passing, which included obtaining money from the residents' trust accounts for the residents to participate in the activities.

During an interview with the Administrator, they stated they did not know who had provided the authorization for the charges to resident #003's trust account prior to 2018 [although the resident had been admitted to the home for a particular period of time]. The Administrator stated that there may have been verbal authorization at some time for the trust account charges as there was no evidence of written authorization. They also stated that, with respect to the charges to resident #001's trust account, there was no person acting on behalf of the resident, who had provided written authorization for specific charges to the resident's trust account, and there was no person acting on behalf of the resident for any management of their property for a period of time. The Administrator indicated that there was no written authorization for the charges to resident #007's trust account for the items listed on the trust ledger. The Administrator identified that resident #013 had not

had a person in place to manage their property from 2017 to 2018, until a trustee was appointed to manage the resident's property. The Administrator acknowledged that the resident had been charged for an item without written authorization. With respect to resident #004, the Administrator identified that no written authorization had been provided for the charges to their trust account for multiple items.

During an interview with the Director of Finance, they confirmed that the charge for TV was approximately $32.00 per month and not the other amounts [$18.00, $20.00, $21.00] listed in older versions of the Appendix to Form A: Price/Charge List, which accompanied the Purchase of Services Agreements or Form A Resident Charges & Trust Account Authorization. They also stated that they were not sure of the exact charge for Handi van transportation [each appendix reviewed in the residents' financial files listed the charge as $1.50 each way, but $2.00 was charged each way from the residents' trust accounts] but the cost of the Handi van had gone up. They stated the residents, or persons acting on behalf of residents were not asked to provide written authorization for changes in fees, as they only provided written authorization once, on admission. The Director of Finance stated that residents, or persons acting on behalf of residents, should sign a new Purchase of Services Agreement when costs changed but "it looks like it is not happening". They acknowledged that the agreement and appendix did not include the amount of the charges the resident, or person acting on behalf of the resident, was required to sign to provide written authorization for all of the items listed. The Director of Finance indicated that the home did not have a process in place to determine if a resident was capable of managing their own property, or if a referral was required to initiate the process for legal trustee options. [s. 241. (8)]

7. The licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, has failed to ensure that it did not receive, hold or administer the property of a resident in trust other than as provided for in this section.

A complaint was submitted to the Director related to resident finances in the home.

A review of resident #004's financial file included an Appointment of Trustee application dated 2009, signed by former Financial Officer #112 which identified their relationship to the resident as "Financial Officer at LTC Home – place of residence". The application included a signed acknowledgement that "My appointment does not place me in the position of any potential financial gain or in a conflict of interest position as a result of my appointment".

A review of an email thread identified that:
- on a date in 2015, Finance Clerk #113 sent an email attachment titled "ODSP Trustee Withdrawal Letter Re [Financial Officer #112]" to the Financial Services employee #103, former Administrator #114 and the Director of Finance #107;
- on another date in 2015, former Administrator #114 responded that they had been in contact with "ODSB" regarding withdrawal of the trustee and "The new trustee is the Administrator of Rainycrest, it will be whoever occupies the position of Administrator of the facility and not attached to an individual";
- on a date in 2018, Financial Services employee #103 emailed the Director of Finances and identified that resident cheques were made out to "Administrator of Rainycrest", that the current Administrator #100 felt that this was a conflict of interest, and the Financial Services employee didn't know how anyone else could not have thought of that before.

A review of a fax from the Director of Finance, identified that the home's former Financial Officer #112 had been appointed resident #004's trustee for years, when the trustee was then changed to the Administrator of the home. In 2018, an alternate trustee had been appointed. The Inspector also noted that the fax identified the home's former Administrator #115 as resident #005's trustee for a specific number of years, until the resident's discharge from the home. Administrator #115 had not been an employee of the home for years prior to the resident's discharge.

During an interview with Administrator #100, they acknowledged that Financial Officer #112 had been appointed trustee for resident #004's finances, that this was not a standard or acceptable practice, and that it was a conflict of interest.

During an interview with Inspector #625, the Director of Finance stated that Financial Officer #112 had been resident #004's trustee for finances, that it had then been changed to the home's Administrator until the resident obtained an alternate trustee. The Director of Finance stated that this was "absolutely not" an appropriate trustee for the resident and that it was a conflict of interest to have a home's employee act in the position of trustee for resident finances. [s. 241. (12)]

8. Inspector #625 reviewed the home's policy titled "Resident Trust Accounts – ORG-I-FIN-10", effective April 26, 2018. The policy identified "Where [the licensee] administered the resident's income, funds in excess of the maintenance costs would be deposited as per the resident's request, in the resident's personal

account or the trust account."

During an interview with Inspector #625, the Director of Finances stated that the term "maintenance costs" cited in this section of the licensee's policy referred to accommodation fees charged to residents. They stated the licensee processed government cheques (mainly pension cheques) for multiple residents in the home by depositing the cheques into the residents' trust accounts from which the residents' accommodation costs were paid. The Director of Finance stated the residents whose government cheques and accommodation payments were handled in this manner did not have anyone to act on their behalf to have the money deposited elsewhere. [s. 241. (12)]

***Additional Required Actions:***

**CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)The following order(s) have been amended:CO# 002,003**

***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 that ensures that:***
***- the licensee holds no more than $5,000 in a trust account for any resident at any time;***
***- the licensee establishes a written policy and procedures for the management of resident trust accounts and the petty cast trust money, which must include (a) a system to record the written authorizations required under subsection (8); and (b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money;***
***- the licensee provides a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; and***
***- the licensee provides to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 ensure that residents were protected from abuse by anyone.

Ontario Regulation 79/10, s. 2 (1) defines "financial abuse" as any misappropriation or misuse of a resident's money or property.

A complaint was submitted to the Director related to resident finances in the home.

The Inspector reviewed resident #004's financial file which included:
- An Appointment of Trustee document, dated years earlier, identifying the home's Financial Officer as the resident's trustee. The document identified the Financial Officer's relationship to resident #004 as "Financial Officer at LTC Home – place of residence", and contained the Financial Officer's signature acknowledging "My appointment does not place me in the position of any potential financial gain or in a conflict of interest position as a result of my appointment"; and
- A document dated 2018, that identified the resident had never managed their finances independently since their admission to the home and that the resident was informed, if they were found incapable to manage their finances, that the Office of the Public Guardian and Trustee (PGT) would take over complete management of their money, including receiving the resident's money, making all bill payments and financial decisions for the resident, and giving the resident a daily spending allowance. The report also identified that, an alternate entity would appoint a guardian in a particular circumstance; and
- a document that identified resident #004 as incapable of managing property dated 2018.

The Inspector also reviewed an email thread which identified that Finance Clerk #113 sent an email attachment titled "ODSP Trustee Withdrawal Letter Re [Financial Officer #112]" to Financial Services employee #103, former Administrator #114 and the Director of Finance, years after the Appointment of Trustee document was dated. Former Administrator #114 responded that they have been in contact with "ODSB" regarding withdrawal of the trustee and "The new trustee is the Administrator of Rainycrest, it will be whoever occupies the position of Administrator of the facility and not attached to an individual." In 2018, Financial Services employee #103 emailed the Director of Finances and identified that [resident #004's] cheques were made out to "Administrator of Rainycrest" and that the current Administrator #100 felt that this was a conflict of interest, and the Financial Services employee didn't know how anyone else had not thought of that before.

A review of documents provided by the Director of Finance, identified that the home's former Financial Officer #112 had been appointed resident #004's trustee over multiple years, when the trustee was then changed to the Administrator of the home. Following which, in 2018, a trustee from an alternate entity had been appointed.

A review of a letter dated 2018, identified an alternate entity had exclusive jurisdiction over the property of the resident who had been found to be incapable of managing their own financial affairs, by virtue of a specific legal jurisdiction.

Inspector #625 also noted that, in 2017 and 2018, residents #004's trust account, for which the home's Financial Officer and Administrators had held the position of trustee, had balances which exceeded the permissible $5,000 amount. The trust account had a balance greater than $5,000.00 and had been held in the non-interest bearing trust account when the home's staff were in the position of trustee for the resident. The Inspector noted that resident #004's Resident Admission Agreement, dated years earlier, indicated that the home provided an interest bearing bank account and that interest earned was added to the trust account on a monthly basis. The trust account also had charges and withdrawals for which there was no written authorization. Resident #004's Resident Ledger Trust Detail Report included withdrawals from the resident's trust account for multiple items, which the resident had been charged for without written authorization. The ledger indicated that the resident had withdrawn cash on multiple occasions in 2017 and 2018 and had withdrawn a specific amount of cash over a period of time from their trust account.

A review of Resident Ledger Receipts identified that receipts indicating how the money was spent had not been provided to the home for full and partial withdrawal amounts. There were no attached receipts to identify how the resident had spent the money for 82 per cent of the Resident Ledger Receipts.

During an interview with Receptionist #102, they stated that they had been told by Recreation Manager #110 that resident #004 could withdraw money and spend it on whatever they wanted as it would be taken away if the resident didn't spend it. The Receptionist stated that the Administrator at the time knew this and allowed them to give the resident whatever amount of money they wanted. The Receptionist stated that it was typical practice at times, for residents who were accompanied by staff, to withdraw hundreds of dollars and that residents did not always return with receipts or money to redeposit into their trust account.

During an interview with Activity Assistant #105, they acknowledged that they had accompanied resident #004 on several outings where the resident had withdrawn money. The Activity Assistant stated that their Supervisor, Recreation Manager #110 had provided authorization for resident #004 to withdraw money from their

trust account. The Activity Assistant identified that they had been involved in a larger purchase for the resident, which cost hundreds of dollars. The Activity Assistant stated that RPN #109 had informed them that the resident had money in their trust account had to use it or it would be taken away, it seemed like time was of the essence and that if they didn't spend it for the resident "it would evaporate". They also stated the resident withdrew money for items and they knew that residents had the authority or capacity to withdraw the money because they asked the resident and "they [said] yes or not". They stated that some resident money was kept on the unit for a recreational activity, and identified that resident #004 had paid for a particular activity for the residents on their unit.

Inspector #625 entered the unit and observed resident #004 ask Activity Assistant #105 to accompany them to obtain money for an activity. The Activity Assistant explained to the Inspector that the resident regularly asked to withdraw money for the activity.

On the unit, Activity Assistant #105 showed the Inspector nine plastic bags in an unlocked plastic portable drawer that contained various amounts of change. The Activity Assistant stated there was also a locked metal box that resident money was kept in but they were not able to locate the box at the time of the inspection. They stated that some of the money contained in the box was donated money and that there was no ledger or written record kept of the monetary transactions in either location.

During an interview with RPN #109, they stated they thought resident #004 needed to spend their money or it would be taken away but could not recall who had informed them of that. The RPN stated that they were not aware that resident #004 did not have approval to withdraw money from their trust account, that they had believed the resident could withdraw money and manage their own finances and they were not aware that the resident was not able to manage their property. The RPN stated they knew of the unit activity paid for by the resident and that the resident asked about participating in another activity.

With respect to resident #004, the Administrator identified that the resident had greater than $5,000 in their trust account and no written authorization had been provided for the charges to their trust account for numerous items. They acknowledged that Financial Officer #112 had been appointed trustee for resident #004's finances, that this was not a standard or acceptable practice, and that it was a conflict of interest. The Administrator acknowledged that it was not appropriate

for a resident who was not capable of managing their own property to pay for an activity for the residents on the unit which they resided on, and stated there was no reason why the resident would need to spend their money or it would be lost to them.

During an interview with Financial and Statistical Analyst #106, they confirmed they had been aware that the home's former employee, Financial Officer #112 had been appointed trustee for resident #004 years earlier, which had been approved by the Administrator in the home at that time. They indicated that items charged to the resident's trust account had not been authorized according to the written authorization on file. They stated that the resident withdrew money on their own and had the legal authority to do so because "it's [their] money" but stated they did not know if the resident could withdraw all of the money in their trust account. They stated that the person legally responsible for the resident's property would have the authority to decide the amount of any personal withdrawals from the trust account. The Financial and Statistical Analyst reviewed resident #004's Admission Agreement that identified the resident's family member #111 as the substitute decision-maker (SDM) for the resident's finances but stated they did not know if the document [provided by the home] had been reviewed by a lawyer at the time.

During an interview with the Director of Finance, they stated that Financial Officer #112 had been resident #004's trustee for finances, that it had then been changed to the home's Administrator until the resident obtained an alternate trustee. The Director of Finance stated that this was "absolutely not" an appropriate trustee for the resident and that it was a conflict of interest to have a home's employee act in the position of trustee for resident finances.

In summary, the licensee failed to protect resident #004 from financial abuse as:
- The licensee failed to ensure an appropriate person had legal authority with respect to the resident's property, instead Financial Officer #112 and multiple Administrators acted in the role of trustee for the resident's finances;
- The licensee permitted money to be withdrawn by the resident without written authorization for the withdrawals, and without receipts or records being produced to indicate how the money had been spent;
- The licensee permitted charges to the resident's trust account without written authorization for the charges;
- The home's staff perpetuated the belief that the resident would lose any unspent trust account money and supported the resident to withdraw and spend trust account money, on unapproved items and activities, without any checks in place to

alert the home's staff that the resident required approval from a legal trustee; and
- The home's Activity staff kept undocumented money for multiple residents, including resident #004, on a unit without record of the amounts deposited, how the money was spent, or on what the money was spent. [s. 19. (1)]

***Additional Required Actions:***

**CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)The following order(s) have been amended:CO# 004**

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**WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 misuse or misappropriation of a resident's money had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulation 79/10, s. 2 (1) defines "financial abuse" as any misappropriation or misuse of a resident's money or property.

A complaint was submitted to the Director related to resident finances in the home.

During interviews with the Director of Finance, they stated that the licensee had measures in place to identify potential resident financial abuse from family members and provided an example that they had been alerted by a bank that, since resident #018's admission to the home years prior, their family member #118 had withdrawn money from the resident's account and had spent it on themself. The Director of Finance thought the bank had informed the police of this and stated that the home's population was vulnerable, families could take residents' money and numerous families had gone to collections. The Director of Finance stated the home's current Administrator #100 would have a copy of a Critical Incident System report for this financial abuse, if one had been sent to the Director.

Inspector #625 reviewed emails, provided by the Director of Finance, related to financial misappropriation of residents' finances as follows:
(1) An email from the licensee's Director of Finance, that stated resident #018 had a current outstanding balance, the licensee had never received payment from resident #018's family member #118 despite numerous attempts to set up a payment plan, that family member #118 no longer responded to the home's requests, and that the resident could not manage their own affairs.

The email also identified that resident #010 had a current outstanding balance, the resident's family member #120 agreed to settle the outstanding payment but the licensee could no longer mail, phone or contact them in any way. The Administrator and nursing staff had confirmed resident #010 was not capable of handling their own affairs, and the licensee had historically had issues with the family member not leaving appropriate funds to cover the cost of the resident's care.

(2) An email titled Potential Elder Abuse Situation ..., that identified resident #018's family member #118 appeared to have misappropriated funds. The email also identified that a representative at Public Guardian and Trustee "was a bit surprised it was us [an external organization] calling rather than Riverside calling them, as this is more of a problem for Riverside than us. It may make sense to ask them to take the lead" The email thread had been sent to the licensee's Director of Finances.

(3) An email titled from the licensee's Director of Finances, that identified the licensee had "gone to great lengths to attempt to recover some of the dollars owing the licensee for [resident # 018's] LTC stay. Unfortunately, [the resident's family member # 118] had access to [the resident's] bank account and was using the funds for other means...."

During phone interviews with Inspector #625, the home's current Administrator #100 stated that financial misappropriation had occurred if resident #018 had money diverted elsewhere instead of being used to pay their bills. The Administrator identified that the home's staff had informed them that the financial abuse started before 2017, but they were not able to find a CIS report for resident #018 for 2015, 2016 or 2017, related to the financial abuse that had occurred. The Administrator indicated that Financial Services employee #103 had stated they had notified the home's previous Administrators #123 and #114 that financial abuse had been occurring with residents #018 and #010 but the current Administrator was not able to locate investigation files for either residents and there was no indication that the police had been notified. The Administrator indicated that the bank had notified the licensee of the financial misappropriation of resident #018, that PGT became involved, and the resident had been discharged several months afterwards, before there was an opportunity to recover the lost money. With respect to resident #010, the Administrator stated, that they had learned the resident's family member #120 had used the resident's money in their bank account for themself and not for the resident. The Administrator stated that, unfortunately, it looked like nothing had been done in either of these serious situations. [s. 24. (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 that ensures that a person who has reasonable grounds to suspect that misuse or misappropriation of a resident's money occurred, or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager**

**Specifically failed to comply with the following:**

**s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian.

A complaint was received by the Director related to personal care concerns affecting resident #002, which included allegations of weight changes.

During an interview with Registered Dietitian (RD) #124, they reported to Inspector #621 that the home was recruiting for a Nutrition Manager (NM) since the previous one had left the organization the spring of 2018. They reported that NM #125 was the acting NM for the home.

During an interview with Food Services Supervisor (FSS) #126, they reported to Inspector #621 that the home had an acting NM since the previous NM #127 vacated the role. The FSS identified that acting NM #125 assumed the position, with a plan to continue in the role until the position was permanently filled. Additionally, the FSS confirmed that the acting NM was not a Registered Dietitian (RD), and did not possess active membership in the Canadian Society of Nutrition Management (CSNM) when they assumed the role of NM for the home.

During an interview with Administrator #100 they reported to Inspector #621 that the acting NM had just completed an exam with the CSNM, and on review of a certificate of membership, confirmed that active membership with the CSNM began after they had started in the position. The Administrator confirmed that the acting NM had been neither a RD or an active member of CSNM for 47 days, when they were actively working in the capacity of NM for the home. [s. 75. (2)]

***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 that ensures that a person hired as a nutrition manager after the coming into force of this section is an active member of the Canadian Society of Nutrition Management or a registered dietitian, to be implemented voluntarily.***

**Issued on this 31 day of October 2018 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**
**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** Amended by MICHELLE BERARDI (679) - (A2)

**Inspection No. / No de l'inspection :** 2018_703625_0014 (A2)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / No de registre :** 007447-18, 011226-18 (A2)

**Type of Inspection / Genre d'inspection:** Complaint

**Report Date(s) / Date(s) du Rapport :** Oct 31, 2018;(A2)

**Licensee / Titulaire de permis :** Riverside Health Care Facilities Inc.
110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7

**LTC Home / Foyer de SLD :** Rainycrest
550 Osborne Street, FORT FRANCES, ON, P9A-3T2

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Marva Griffiths

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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To Riverside Health Care Facilities Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with s. 8 (1) of Ontario Regulation 79/10.

The licensee shall ensure that, where the LTCHA or Ontario Regulation 79/10 require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, is complied with.

Ontario Regulation 79/10, s. 241 (5) requires every licensee to establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money.

Specifically the licensee must:
(a) Ensure the home's written policy and procedures for the management of resident trust accounts and petty cash trust money are compliant with applicable legislation.
(b) Review and revise the Resident Trust Accounts policy, soliciting and considering input from staff who are required to follow the policy.
(c) Provide training to staff who are required to follow the licensee's Resident Trust Accounts policy including, but not limited to, the Receptionist, the Financial Services employee, the Financial and Statistical Analyst, the Director of Finances, the home's interdepartmental management team and the Administrator. The training should include a review of the updated policy and related procedures and each employee's roles and responsibilities in following the policy and procedures.
(d) Monitor the employees' adherence to the resident trust accounts and the petty cash trust money policy and procedures, by conducting routine audits of resident's financial records. Maintain records of the audits including the date of the audit, the name and title of the person conducting the audit, the results of the audit, the corrective action taken to address any deviations from the policy, and the outcome of the actions taken.

**Grounds / Motifs :**

1. The licensee has failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10, s. 241 (5) identifies that every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed the home's policy titled "Resident Trust Accounts – ORG-I-FIN-10", effective April 26, 2018. The policy identified that:

(a) The licensee must provide the resident, or person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any person, for deposit in the trust fund on behalf of the resident.

The licensee's Resident Trust Accounts policy was not complied with as written receipts had not been provided to residents, or any other person, for all deposits made into trust accounts on behalf of the resident.

During an interview with Financial Services employee #103, they stated that they did not provide written receipts for deposits to resident trust accounts made by cheque and received through the mail.

(b) Verbal authorization was not acceptable if a resident, or a person acting on behalf of a resident (who had legal authority to manage the resident's property), wished to pay for charges with money from a trust account.

The licensee's Resident Trust Accounts policy was not complied with as verbal authorization had been accepted for recreational activity charges from residents' trust accounts.

During reviews of Resident Ledger Trust Account Detail Reports and Purchase of Services agreements for residents #013 and #004, it was identified that they were charged for for specific items without written authorization.

During an interview with Activity Assistant #105, they stated that they obtained verbal consent for residents to participate in recreational activities at times, when they spoke to family in passing, which included obtaining money from the residents' trust accounts for the residents to participate in the activities.

(c) Financial staff (designated Financial and Statistical Analyst) were to review reports daily and ensure they balanced with the trust ledger.

The licensee's Resident Trust Accounts policy was not complied with as the review of identified reports was completed less than daily.

During an interview with Receptionist #102, they stated that they did not provide the Financial and Statistical Analyst with the reports referred to in the policy for daily review, but rather provided the reports to the analyst at a lesser frequency.

(d) Any withdrawal request greater than $100.00 would be issued by cheque or authorized, in writing, by the Long Term Care Home or Eldcap facility Administrator and the resident or any person acting on behalf of the resident (who had legal authority to manage the resident's property).

The licensee's Resident Trust Account policy was not complied with as withdrawal requests greater than $100.00 had not been issued by cheque or authorized in writing by the home's Administrator.

Resident #007's Resident Ledger Trust Detail Report identified a personal withdrawal of greater than $100.00 on a date in the spring of 2018.

During an interview with resident #007, they stated they had withdrawn in excess of $100.00 for a particular purpose.

During an interview with the Administrator, they stated that, although the licensee's Resident Trust Accounts policy, effective April 26, 2018, indicated they were required to provide written authorization for withdrawals greater than $100.00, they had not provided this written authorization to date.

(e) Detailed trust statements were to be prepared by the Financial and Statistical Analyst. Statements would be printed and distributed when the trust account balance was zero or the account was in arrears. For an overdrawn account, all preauthorized transactions and withdrawal requests would cease immediately.

The licensee's Resident Trust Accounts policy was not complied with as preauthorized transactions and withdrawal requests had not immediately ceased

when residents' trust account balances were zero or the accounts were in arrears.

A review of resident #007's Resident Ledger Trust Detail Report with a focus on the date the policy came into effect, April 26, 2018, identified that the resident made personal withdrawals and had charges withdrawn from the account despite the balance being negative. A personal withdrawal made by the resident, on a date in the spring of 2018, put the resident's trust account into a negative balance, after which multiple charges and another personal withdrawal occurred, further putting the trust account balance into arrears.

During an interview with Receptionist #102, they stated that resident #007 had withdrawn money in the spring of 2018 that put their trust account into a negative balance. The Receptionist stated they continued to provide resident #007 with money when their account had a negative balance. The Receptionist also stated they were required to process cheques for incurred costs whether or not the resident's trust account balance was zero or in arrears.

(f) The management and administration of residents' funds is governed by the provision of the Ministry of Health and Long-Term Care and the Long-Term Care Homes Act, 2007.

The licensee's Resident Trust Accounts policy was not complied with as the management and administration of residents' funds was not governed by the provisions of the LTCHA, as the home failed to establish and maintain a trust account for convalescent care residents.

The Long-Term Care Homes Act, 2007, c. 8, s. 183 (2) (o) identifies that, without restricting the generality of subsection (1), the Lieutenant Governor in Council may make regulations requiring licensees to establish trust accounts for residents, and governing the administration of the trust accounts.

Ontario Regulation 79/10, s. 241 (1) identifies that every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. The legislation does not exclude convalescent care residents from depositing money into a trust account.

The home was not able to provide Inspector #625 with a financial file for former

convalescent care resident #017.

During an interview with the Administrator, they stated that resident #017 did not have a financial file containing financial documents as the accommodation fee for the convalescent care resident was funded and not paid by the resident. With respect to the other financial agreements in place for long term residents in the home [specifically the Purchase of Services Agreement], the Administrator stated there were no agreements in place for convalescent care residents.

During an interview with the Director of Finance, they stated that the licensee did not offer trust accounts to convalescent care residents as it was too hard to manage if they only resided in the home for three months. The Director also stated that they did not enter into Purchase of Services agreements with the convalescent care residents, as the licensee only offered convalescent care residents phone and TV services, which would not be paid from a resident trust account as the convalescent care residents would not have one in place.

(g) The resident or any person acting on behalf of the resident (who has legal authority to manage the resident's property), was required to provide written authorization to the licensee for all preauthorized personal withdrawals from the resident's trust account. The Service Agreement defined all preauthorized withdrawals and/or charges.

The licensee's Resident Trust Accounts policy was not complied with as the home permitted a person, who did not have legal authority to manage a resident's property, to enter into a written agreement with the licensee preauthorizing personal withdrawals from the resident's trust account as detailed in their signed Purchase of Service Agreement.

A review of resident #019's financial file identified that the resident signed their own Accommodation Agreement on  a date in the summer of 2017, while the resident's family member #116 signed the resident's Purchase of Services Agreement and accompanying Form A Resident Charges and Trust Account Authorization on the same date. Family member #116 signed in the area designated for the resident's "Power of Attorney for Property/Guardian/Trustee".

A faxed document provided by the Director of Finance identified that resident #019 had the legal authority to manage their own finances from the date of their

admission.

During an interview with resident #019, they were able to accurately recall details related to their admission and time in the home, and that family member #116 had signed admission papers.

During an interview with the Financial and Statistical Analyst, they stated that resident #019's accommodation statements were sent to the resident while their trust account statements were sent to the resident's other family member #117, but that resident #019 was legally responsible for their own accommodation and trust accounts. They identified that the resident would be legally responsible for their accommodation and trust accounts and, as per their admission agreements, that the resident had the legal authority to enter into a legal contract with the home, not family member #116.

During an interview with the Administrator they stated that, on admission, the home determined who was able to sign the admission documents if they were the resident, the substitute decision-maker, had power of attorney or were the Office of the Public Guardian and Trustee. The Administrator stated that another person could not enter into a legal agreement with the home on behalf of a resident if the resident was still capable.

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to occur. The scope of the issue was a level 2 as the home had demonstrated a pattern of failing to follow the Resident Trust Accounts policy in multiple areas. The home had a level 2 compliance history as it had multiple unrelated areas of non-compliance issued in the last three years. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :**

Jan 15, 2019(A2)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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**Order # / Ordre no :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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).

**Order / Ordre :**

The licensee must be compliant with s. 241 (8) of Ontario Regulation 79/10.

The licensee must ensure that 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 provides 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.

Specifically the licensee must:
(a) Develop and implement a policy or a procedure that details the process for obtaining and maintaining written authorization for charges with money from a trust account, ensures that only charges authorized in writing are withdrawn from residents' trust accounts, and meets the applicable requirements in the legislation.
(b) Review all residents' financial files and ensure current written authorizations for payment for charges with money from residents' trust accounts have been signed by the resident or by a person who has the legal authority to provide the authorization. Ensure the written authorization 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.
(c) Provide training on the procedure and system to the staff who will be involved in the procedure and system, clearly identifying their roles and responsibilities.
(d) Maintain records of the training provided including the date, the attendees, the content, and the trainers.
(e) Monitor the employees' adherence to the resident trust accounts written authorization for charges procedure(s), by conducting routine audits of residents' financial records.
(f) Maintain records of the audits including the date of the audit, the name and title of the person conducting the audit, the results of the audit, the corrective action taken to address any deviations from the policy, and the outcome of the actions taken.

**Grounds / Motifs :**

1. The licensee has failed to ensure that a resident, or a person acting on behalf of a

resident, who wished to pay a licensee for charges under section 91 of the Act with money from a trust account provided a written authorization that specified what the charge was for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed Form A Resident Charges & Trust Account Authorization included in the home's current admission package. The form identified that authorization for charges could be provided by the resident for tuck shop items, recreational events and outings, hair stylist and barber services, cable television, drugs not covered under Ontario Drug Benefit Plan (ODB), transportation, alcoholic beverages, advanced foot care and community support services. The form stated that the amount of charge or cost for each service was set out in the appendix to the form, and the resident should complete a new form if they wanted to change their trust account authorization.

The current corresponding Appendix to Form A: Price/Charge List identified tuck shop charges would "vary according to item and number of purchases", recreational events and outings "As per arrangement for each individual outing", cable television "$33.11 per month", drugs not covered under ODB "The amount of money the Home withdraws from the trust account will vary according to the number of filled prescriptions not covered by ODB", transportation "Handi van cost is $2.00 one-way", alcoholic beverages "each alcoholic drink is $2.00" and advanced foot care "As per arrangement with provider". The appendix identified "You may want to change your trust account authorization following a change in price or charges. If so, you must complete a new authorization form, which the home will provide to you on request."

Neither document identified the amount of the charges for tuck shop items, recreational events and outings, or drugs not covered under ODB.

Inspector #625 reviewed resident #003's financial file including the Form A Resident Charges & Trust Account Authorization dated 2018. The form identified that authorization was provided by the resident's SDM for specific items. The form did not provide written authorization to the licensee for the amount of the charges authorized for these items.

The Inspector reviewed resident #001's financial file including their Purchase of

Services Agreement dated 2011. The agreement did not authorize charges for specific items. The attached Appendix to Form A: Price/Change List listed cable television charges as $18.00 per month, transportation as $1.25 each way for the Handi van and a specific care charge as $25.00 per visit. Resident #001's 2017 Resident Ledger Trust Detail Report identified that the resident had been charged for items without written authorization in place.

Inspector #625 reviewed resident #007's Purchase of Services Agreement dated 2013, which included authorization for specific items. The Attached Appendix to Form A Price/Change List identified the cable television charge as $20.00, the Handi van as $1.25 one way and alcoholic drinks as $2.00 each. Resident's 2017 and 2018 Resident Ledger Trust Detail Reports listed charges that differed from the written authorized amounts and contained charges for items without written authorization.

During an interview with resident #007, they stated that specific items had been paid from their trust account, including one item they usually paid for in another manner. The resident stated they did not think the home should have paid for a particular item from their trust account and the home did not have their authorization to do so.

The Inspector reviewed resident #013's Purchase of Services Agreement dated 2014, and amended in 2015, which did not provide written authorization for charges for an item. The Appendix to Form A: Price/Change List identified cable television as $21.00 per month and Handi van transportation as $1.25 one way. The Resident Ledger Trust Detail Reports for 2017 and 2018 identified charges for specific items and amounts. Resident #013 had been charged an amount that differed from the written authorized charge and for an item without written authorization.

The Inspector reviewed resident #004's Rainycrest Long Term Care Resident Admission Agreement which included a Schedule B Unfunded Services Authorization Form dated 2009. The form authorized the home to bill the resident one particular item, and identified "No" beside "Comfort Trust Account". The admission agreement did not authorize charges other specific items. Resident #004's Resident Ledger Trust Detail Reports for 2017 and 2018 included withdrawals from the resident's trust account for multiple items without written authorization.

The licensee's policy titled "Resident Trust Accounts - ORD-I-FIN-10", effective April 26, 2018, identified "A resident, or person acting on behalf of a resident (who has legal authority to manage the resident's property), who wishes to pay RCH for

charges under section 91 of the LTCHA with money from a trust account shall provide RHC with a written authorization that indicates 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. Verbal authorization is not acceptable."

During an interview with Activity Assistant #105, they stated that they obtained verbal consent for residents to participate in recreational activities at times, when they spoke to family in passing, which included obtaining money from the residents' trust accounts for the residents to participate in the activities.

During an interview with the Administrator, they stated they did not know who had provided the authorization for the charges to resident #003's trust account prior to 2018 [although the resident had been admitted to the home for a particular period of time]. The Administrator stated that there may have been verbal authorization at some time for the trust account charges as there was no evidence of written authorization. They also stated that, with respect to the charges to resident #001's trust account, there was no person acting on behalf of the resident, who had provided written authorization for specific charges to the resident's trust account, and there was no person acting on behalf of the resident for any management of their property for a period of time. The Administrator indicated that there was no written authorization for the charges to resident #007's trust account for the items listed on the trust ledger. The Administrator identified that resident #013 had not had a person in place to manage their property from 2017 to 2018, until a trustee was appointed to manage the resident's property. The Administrator acknowledged that the resident had been charged for an item without written authorization. With respect to resident #004, the Administrator identified that no written authorization had been provided for the charges to their trust account for multiple items.

During an interview with the Director of Finance, they confirmed that the charge for TV was approximately $32.00 per month and not the other amounts [$18.00, $20.00, $21.00] listed in older versions of the Appendix to Form A: Price/Charge List, which accompanied the Purchase of Services Agreements or Form A Resident Charges & Trust Account Authorization. They also stated that they were not sure of the exact charge for Handi van transportation [each appendix reviewed in the residents' financial files listed the charge as $1.50 each way, but $2.00 was charged each way from the residents' trust accounts] but the cost of the Handi van had gone up. They stated the residents, or persons acting on behalf of residents were not asked to provide written authorization for changes in fees, as they only provided written

authorization once, on admission. The Director of Finance stated that residents, or persons acting on behalf of residents, should sign a new Purchase of Services Agreement when costs changed but "it looks like it is not happening". They acknowledged that the agreement and appendix did not include the amount of the charges the resident, or person acting on behalf of the resident, was required to sign to provide written authorization for all of the items listed. The Director of Finance indicated that the home did not have a process in place to determine if a resident was capable of managing their own property, or if a referral was required to initiate the process for legal trustee options.

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to occur. The scope of the issue was a level 2 as the home demonstrated a pattern of non-compliance. The home had a level 2 compliance history as it had multiple unrelated areas of non-compliance issued in the last three years. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :**

Jan 15, 2019(A2)

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**Order # /**
**Ordre no :** 003

**Order Type /**
**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 241. (12) A licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, shall not receive, hold or administer the property of a resident in trust other than as provided for in this section. O. Reg. 79/10, s. 241 (12).

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

**Order / Ordre :**

The licensee must be compliant with s. 241 (12) of Ontario Regulation 79/10.

The licensee must ensure that a licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, shall not receive, hold or administer the property of a resident in trust other than as provided for in this section.

Specifically the licensee must:
(a) Review all residents' financial files and ensure that the licensee does not receive, hold or administer the property of a resident in trust other than as provided for in the legislation.
(b) Identify any residents for which the home is not compliant with this legislation and take immediate action to become compliant.
(c) Maintain a record of the review, including each residents' name, the person who receives, holds or administers the property of each resident in trust, and their relationship to the resident.

**Grounds / Motifs :**

1. The licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, has failed to ensure that it did not receive, hold or administer the property of a resident in trust other than as provided for in this section.

A complaint was submitted to the Director related to resident finances in the home.

Inspector #625 reviewed the home's policy titled "Resident Trust Accounts – ORG-I-FIN-10", effective April 26, 2018. The policy identified "Where [the licensee] administered the resident's income, funds in excess of the maintenance costs would be deposited as per the resident's request, in the resident's personal account or the trust account."

During an interview with Inspector #625, the Director of Finances stated that the term "maintenance costs" cited in this section of the licensee's policy referred to accommodation fees charged to residents. They stated the licensee processed government cheques (mainly pension cheques) for multiple residents in the home by depositing the cheques into the residents' trust accounts from which the residents' accommodation costs were paid. The Director of Finance stated the residents whose government cheques and accommodation payments were handled in this manner did not have anyone to act on their behalf to have the money deposited elsewhere. (625)

2. A complaint was submitted to the Director related to resident finances in the home.

A review of resident #004's financial file included an Appointment of Trustee application dated 2009, signed by former Financial Officer #112 which identified their relationship to the resident as "Financial Officer at LTC Home – place of residence". The application included a signed acknowledgement that "My appointment does not place me in the position of any potential financial gain or in a conflict of interest position as a result of my appointment".

A review of an email thread identified that:
- on a date in 2015, Finance Clerk #113 sent an email attachment titled "ODSP Trustee Withdrawal Letter Re [Financial Officer #112]" to the Financial Services employee #103, former Administrator #114 and the Director of Finance #107;

- on another date in 2015, former Administrator #114 responded that they had been in contact with "ODSB" regarding withdrawal of the trustee and "The new trustee is the Administrator of Rainycrest, it will be whoever occupies the position of Administrator of the facility and not attached to an individual";
- on a date in 2018, Financial Services employee #103 emailed the Director of Finances and identified that resident cheques were made out to "Administrator of Rainycrest", that the current Administrator #100 felt that this was a conflict of interest, and the Financial Services employee didn't know how anyone else could not have thought of that before.

A review of a fax from the Director of Finance, identified that the home's former Financial Officer #112 had been appointed resident #004's trustee for years, when the trustee was then changed to the Administrator of the home. In 2018, an alternate trustee had been appointed. The Inspector also noted that the fax identified the home's former Administrator #115 as resident #005's trustee for a specific number of years, until the resident's discharge from the home. Administrator #115 had not been an employee of the home for years prior to the resident's discharge.

During an interview with Administrator #100, they acknowledged that Financial Officer #112 had been appointed trustee for resident #004's finances, that this was not a standard or acceptable practice, and that it was a conflict of interest.

During an interview with Inspector #625, the Director of Finance stated that Financial Officer #112 had been resident #004's trustee for finances, that it had then been changed to the home's Administrator until the resident obtained an alternate trustee. The Director of Finance stated that this was "absolutely not" an appropriate trustee for the resident and that it was a conflict of interest to have a home's employee act in the position of trustee for resident finances.

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to occur. The scope of the issue was a level 2 as the home demonstrated a pattern of the same practice occurring. The home had a level 2 compliance history as they had as had multiple unrelated areas of non-compliance issued in the last three years. (625)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :**

Jan 15, 2019(A2)

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**Order # /**
**Ordre no :** 004

**Order Type /**
**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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).

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act.

The licensee shall ensure that resident are protected from abuse by anyone, and are not neglected by the licensee or staff.

Specifically the licensee must:
(a) Develop and implement policies and/or procedures that address the concerns identified in the finding, with respect to resident #004 and all residents in the home, including:
(i) the determination of a resident's capacity to manage their own property and the communication of their capacity to manage property to appropriate staff;
(ii) the identification of legally authorized individuals to act as a substitute decision-maker or trustee for a resident and the inclusion of supporting documents in the resident's file;
(iii) the process to obtain written authorization for resident charges from a person with the legal authority to provide such 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;
(iv) the process and parameters by which a resident, or a person with legal authority to act on behalf of a resident, withdrawals money from a trust account, addressing the legal requirements for the withdrawal (capacity, written authorization for specific amounts and frequencies of withdrawals, withdrawal amounts not in excess of resident funds, supportive documentation as to how the money was spent, etc.);
(v) the tracking of money spent when incapable residents are in the care of the home's staff; and
(vi) the holding and tracking of money by home's staff for residents outside of a trust account.

**Grounds / Motifs :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Ontario Regulation 79/10, s. 2 (1) defines "financial abuse" as any misappropriation

or misuse of a resident's money or property.

A complaint was submitted to the Director related to resident finances in the home.

The Inspector reviewed resident #004's financial file which included:
- An Appointment of Trustee document, dated years earlier, identifying the home's Financial Officer as the resident's trustee. The document identified the Financial Officer's relationship to resident #004 as "Financial Officer at LTC Home – place of residence", and contained the Financial Officer's signature acknowledging "My appointment does not place me in the position of any potential financial gain or in a conflict of interest position as a result of my appointment"; and
- A document dated 2018, that identified the resident had never managed their finances independently since their admission to the home and that the resident was informed, if they were found incapable to manage their finances, that the Office of the Public Guardian and Trustee (PGT) would take over complete management of their money, including receiving the resident's money, making all bill payments and financial decisions for the resident, and giving the resident a daily spending allowance. The report also identified that an alternate entity would appoint a guardian in a particular circumstance; and
- a document that identified resident #004 as incapable of managing property dated 2018.

The Inspector also reviewed an email thread which identified that Finance Clerk #113 sent an email attachment titled "ODSP Trustee Withdrawal Letter Re [Financial Officer #112]" to Financial Services employee #103, former Administrator #114 and the Director of Finance, years after the Appointment of Trustee document was dated. Former Administrator #114 responded that they have been in contact with "ODSB" regarding withdrawal of the trustee and "The new trustee is the Administrator of Rainycrest, it will be whoever occupies the position of Administrator of the facility and not attached to an individual." In 2018, Financial Services employee #103 emailed the Director of Finances and identified that [resident #004's] cheques were made out to "Administrator of Rainycrest" and that the current Administrator #100 felt that this was a conflict of interest, and the Financial Services employee didn't know how anyone else had not thought of that before.

A review of documents provided by the Director of Finance, identified that the home's former Financial Officer #112 had been appointed resident #004's trustee over multiple years, when the trustee was then changed to the Administrator of the home.

Following which, in 2018, a trustee from an alternate entity had been appointed.

A review of a letter dated 2018, identified that an alternate entity had exclusive jurisdiction over the property of the resident who had been found to be incapable of managing their own financial affairs, by virtue of a specific legal jurisdiction.

Inspector #625 also noted that, in 2017 and 2018, residents #004's trust account, for which the home's Financial Officer and Administrators had held the position of trustee, had balances which exceeded the permissible $5,000 amount. The trust account had a balance greater than $5,000.00 and had been held in the non-interest bearing trust account when the home's staff were in the position of trustee for the resident. The Inspector noted that resident #004's Resident Admission Agreement, dated years earlier, indicated that the home provided an interest bearing bank account and that interest earned was added to the trust account on a monthly basis. The trust account also had charges and withdrawals for which there was no written authorization. Resident #004's Resident Ledger Trust Detail Report included withdrawals from the resident's trust account for multiple items, which the resident had been charged for without written authorization. The ledger indicated that the resident had withdrawn cash on multiple occasions in 2017 and 2018 and had withdrawn a specific amount of cash over a period of time from their trust account.

A review of Resident Ledger Receipts identified that receipts indicating how the money was spent had not been provided to the home for full and partial withdrawal amounts. There were no attached receipts to identify how the resident had spent the money for 82 per cent of the Resident Ledger Receipts.

During an interview with Receptionist #102, they stated that they had been told by Recreation Manager #110 that resident #004 could withdraw money and spend it on whatever they wanted as it would be taken away if the resident didn't spend it. The Receptionist stated that the Administrator at the time knew this and allowed them to give the resident whatever amount of money they wanted. The Receptionist stated that it was typical practice at times, for residents who were accompanied by staff, to withdraw hundreds of dollars and that residents did not always return with receipts or money to redeposit into their trust account.

During an interview with Activity Assistant #105, they acknowledged that they had accompanied resident #004 on several outings where the resident had withdrawn money. The Activity Assistant stated that their Supervisor, Recreation Manager #110

had provided authorization for resident #004 to withdraw money from their trust account. The Activity Assistant identified that they had been involved in a larger purchase for the resident, which cost hundreds of dollars. The Activity Assistant stated that RPN #109 had informed them that the resident had money in their trust account had to use it or it would be taken away, it seemed like time was of the essence and that if they didn't spend it for the resident "it would evaporate". They also stated the resident withdrew money for items and they knew that residents had the authority or capacity to withdraw the money because they asked the resident and "they [said] yes or not". They stated that some resident money was kept on the unit for a recreational activity, and identified that resident #004 had paid for a particular activity for the residents on their unit.

Inspector #625 entered the unit and observed resident #004 ask Activity Assistant #105 to accompany them to obtain money for an activity. The Activity Assistant explained to the Inspector that the resident regularly asked to withdraw money for the activity.

On the unit, Activity Assistant #105 showed the Inspector nine plastic bags in an unlocked plastic portable drawer that contained various amounts of change. The Activity Assistant stated there was also a locked metal box that resident money was kept in but they were not able to locate the box at the time of the inspection. They stated that some of the money contained in the box was donated money and that there was no ledger or written record kept of the monetary transactions in either location.

During an interview with RPN #109, they stated they thought resident #004 needed to spend their money or it would be taken away but could not recall who had informed them of that. The RPN stated that they were not aware that resident #004 did not have approval to withdraw money from their trust account, that they had believed the resident could withdraw money and manage their own finances and they were not aware that the resident was not able to manage their property. The RPN stated they knew of the unit activity paid for by the resident and that the resident asked about participating in another activity.

With respect to resident #004, the Administrator identified that the resident had greater than $5,000 in their trust account and no written authorization had been provided for the charges to their trust account for numerous items. They acknowledged that Financial Officer #112 had been appointed trustee for resident

#004's finances, that this was not a standard or acceptable practice, and that it was a conflict of interest. The Administrator acknowledged that it was not appropriate for a resident who was not capable of managing their own property to pay for an activity for the residents on the unit which they resided on, and stated there was no reason why the resident would need to spend their money or it would be lost to them.

During an interview with Financial and Statistical Analyst #106, they confirmed they had been aware that the home's former employee, Financial Officer #112 had been appointed trustee for resident #004 years earlier, which had been approved by the Administrator in the home at that time. They indicated that items charged to the resident's trust account had not been authorized according to the written authorization on file. They stated that the resident withdrew money on their own and had the legal authority to do so because "it's [their] money" but stated they did not know if the resident could withdraw all of the money in their trust account. They stated that the person legally responsible for the resident's property would have the authority to decide the amount of any personal withdrawals from the trust account. The Financial and Statistical Analyst reviewed resident #004's Admission Agreement that identified the resident's family member #111 as the substitute decision-maker (SDM) for the resident's finances but stated they did not know if the document [provided by the home] had been reviewed by a lawyer at the time.

During an interview with the Director of Finance, they stated that Financial Officer #112 had been resident #004's trustee for finances, that it had then been changed to the home's Administrator until the resident obtained an alternate trustee. The Director of Finance stated that this was "absolutely not" an appropriate trustee for the resident and that it was a conflict of interest to have a home's employee act in the position of trustee for resident finances.

In summary, the licensee failed to protect resident #004 from financial abuse as:
- The licensee failed to ensure an appropriate person had legal authority with respect to the resident's property, instead Financial Officer #112 and multiple Administrators acted in the role of trustee for the resident's finances;
- The licensee permitted money to be withdrawn by the resident without written authorization for the withdrawals, and without receipts or records being produced to indicate how the money had been spent;
- The licensee permitted charges to the resident's trust account without written authorization for the charges;
- The home's staff perpetuated the belief that the resident would lose any unspent

trust account money and supported the resident to withdraw and spend trust account money, on unapproved items and activities, without any checks in place to alert the home's staff that the resident required approval from a legal trustee; and
- The home's Activity staff kept undocumented money for multiple residents, including resident #004, on a unit without record of the amounts deposited, how the money was spent, or on what the money was spent.

The severity of this issue was determined to be a level 2 as there was the potential for harm to occur. The scope of the issue was a level 2 as a pattern of occurrence was demonstrated. The home had a level 3 compliance history as they had multiple related areas of non-compliance issued in the last three years which included:
- compliance order (CO) #001 issued October 6, 2016 (Complaint inspection #2016_320612_0018);
- a written notification (WN) issued October 6, 2016 (Complaint inspection #2016_264609_0019);
- CO #002 issued February 17, 2017 (Resident Quality Inspection (RQI) #2016_463616_0026);
- a voluntary plan of correction (VPC) issued April 13, 2017 (Critical Incident System (CIS) inspection #2017_395613_0001);
- a VPC issued July 10, 2017 (CIS inspection #2017_435621_0016);
- CO #001 issued September 13, 2017 (RQI #2017_463616_0011);
- CO #004 issued January 10, 2018 (Follow-up inspection #2018_624196_0016); and
- a VPC and Director Referral issued on February 20, 2018 (Complaint inspection #2018_509617_0004). (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :**

Jan 15, 2019(A2)

Ontario

**Ministry of Health and Long-Term Care**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  31  day of October 2018 (A2)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**  Amended by MICHELLE BERARDI - (A2)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

**Service Area Office / Bureau régional de services :** Sudbury