**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 22, 2020 | 2020_594746_0004 | 000518-20 | Critical Incident System |

**Licensee/Titulaire de permis**

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Fosterbrooke
330 King Street West NEWCASTLE ON L1B 1G9

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

AMANDEEP BHELA (746), ANGIEM KING (644)

## Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 13, 14, 18, 20, 21, 24, 25, 26, 27 and 28, 2020.

One log related to trust accounts.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED) and the Business Office Manager (BOM)

During the inspection, the inspectors reviewed resident health records, resident trust account documents, resident business file's, home's investigation records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- 2 WN(s)
- 0 VPC(s)
- 1 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 | Légende<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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

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

**Findings/Faits saillants :**

The licensee failed to ensure that resident #001, #002, #003, #004, #005 and #006 were

protected from financial abuse.

"Abuse"- definition:
2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "financial abuse" means any misappropriation or misuse of a resident's money or property. O.Reg.79/10 s.2(1).

The home submitted a Critical Incident Report (CIS) report to the Ministry of Long-Term Care, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified resident trust accounts had withdrawals with no description of how the money was to be used.

A review of the home's financial audits and investigation records indicated the home has one trust account held at a financial institution managed by staff member #101. The statements for three identified months were reviewed. Cheques were drawn on the account at different times in the year resulting in the account being overdrawn and overdraft charges applied by the bank. The audit report further indicated in an identified year, that 132 cheques were cleared from the bank account. One hundred and twenty-four of these cheques had staff member #101 as the payee. The other eight cheques were issued to the home as payment for resident's maintenance/accommodation bills. The audit further indicated that resident #001, #002, #003, #004, #005 and #006 had significant cash withdrawals from their trust accounts. For these residents, their Ontario Disability Support Program (ODSP) and pension cheques were deposited in the trust account by staff member #101 and cash withdrawals were processed by staff member #101.

A review period for an identified time period of the home’s trust transaction report from Point Click Care (PCC) for withdrawals was carried out for resident #001, #002, #003, #004, #005 and #006 indicated the following:

-Resident #001 had 16 withdrawal transactions, with ten receipts signed by the resident and staff member #101, five missing receipts and one receipt with no signatures.
-Resident #002 had 24 withdrawal transactions, with 20 receipts signed by the resident’s SDM and staff member #101, with one missing receipt and three receipts with no signatures.
-Resident #003 had 26 withdrawal transactions, with six signed receipts by the resident and staff member #101, one missing receipt and 19 receipts with no signatures.
-Resident #004 had ten withdrawal transactions, with one signed receipt by the resident

and staff member #101, one missing receipt and eight receipts with no signatures.
-Resident #005 had 13 withdrawal transactions, with one signed receipt by the resident and staff member #101 and 12 receipts with missing signatures.
-Resident #006 had 21 cash withdrawals, with two receipts signed only by staff member #101, three missing receipts and with 16 receipts with no signatures.

In an interview staff member #101 indicated they had withdrawn the cash from the residents trust account in amounts that had overdrawn on the account which resulted in overdraft charges. The overdraft charges were not replaced back into the trust account. Inspector #746 and Inspector #644 listed out the withdrawal amounts as noted in the audit for resident #001, #002, #003, #004, #005 and #006, staff member #101 confirmed and acknowledged that they withdrew funds from the resident's trust accounts without authorization for personal use. The staff member #101 acknowledged that they had financially abused residents #001, #002, #003, #004, #005 and #006.

In an interview Executive Director (ED) acknowledged resident trust accounts held at a financial institution were overdrawn which resulted in bank charges to the affected residents. The ED further indicated they were not aware of the overdraft until after the internal audit was completed by Corporate, the ED acknowledged there were areas of the trust account policy that the home failed to maintain. The ED indicated that the police were notified on an identified date about the incident, and file was forwarded to the Police Financial Crimes unit for investigation. The ED was advised that in the event a forensic audit report is identified to suggest a crime offence(s) has or have occurred to contact the police.  The ED acknowledged that the licensee failed to ensure that resident #001, #002, #003, #004, #005 and #006 were protected from financial abuse from staff member #101.

The licensee has failed to ensure that resident #001, #002, #003, #004, #005 and #006 were protected from financial. From an identified time period, staff member #101 was able to withdraw frequent and large sums of money from resident trust accounts. The licensee failed to comply with their own internal financial policies, by way of not having two signatures for withdrawals, causing resident trust accounts to receive overdraft charges due to the large amounts of withdrawals, failing to provide copies of itemized trust statements to residents or SDMs, failing in obtaining written authorization forms from resident's or SDMs upon setting up a trust account and failing to include unauthorized withdrawals in the quarterly itemized statements.

***Additional Required Actions:***

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

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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. (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. (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. (9) Where a written authorization has been provided under subsection (8), the licensee is not required to obtain a written acknowledgement of receipt of funds for every authorized withdrawal, but must include these withdrawals in the quarterly itemized statement under clause (7) (f). O. Reg. 79/10, s. 241 (9).**

**Findings/Faits saillants :**

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

resident, are not charged a transaction fee for withdrawals, deposits, or anything else related to money held in trust.

The home submitted a CIS report to the Ministry of Long-Term Care on an identified date, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified residents trust accounts had withdrawals with no description of how the money was to be used.

A review of the home's investigation notes and internal audit conducted by the corporate office of Revera Long Term Care Inc. was initiated in two phases on two identified dates. The audit indicated the home has one trust bank account with a financial institution which was managed by staff member #101. The signatories to the bank account were the Executive Director (ED) and Director of Care (DOC). Available bank statements for identified months were reviewed which Management had provided to the auditor. Cheques were drawn on the account at different times in the year resulting in the account being overdrawn and overdraft charges applied by the bank. This amount represents a reduction in the overall trust balance for residents. The audit report further indicated in an identified year, 132 cheques were cleared from the bank account. One hundred and twenty-four of these cheques had staff member #101 as the payee. The memos on the cheques stated “Trust Petty Cash (PC) Replenishment”. The other eight cheques were issued to the home as payment for resident's maintenance/accommodation bills.

A review of the home's bank statements for the residents trust funds indicated for an identified period the residents were charged as overdraft interest. The statements did not indicate a refund to the residents trust account for the overdraft charges. The home did not provide refund documentation that the funds were credited to the account.

In an interview BOM #101 indicated they had withdrawn the cash from the residents trust account in amounts that had overdrawn on the account which resulted in overdraft charges. The overdraft charges were not replaced back into the Trust account at the time the staff member's employment was terminated on an identified date.

In an interview ED #102 acknowledged there were funds overdraft from the residents trust account with the financial institution which resulted in charges to the residents. The ED further indicated they were not aware of the overdraft until after the internal audit was completed by corporate.

The licensee failed to ensure that residents trust account are not charged a transaction

fee for money held in trust. [s. 241. (4) (c)]

2. The licensee has failed to ensure that a receipt is provided to the resident or a person acting on behalf of a resident for all money received and deposited into a trust account.

The home submitted a CIS report to the Ministry of Long-Term Care on an identified date, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified residents trust accounts had withdrawals with no description of how the money was to be used.

A review of the home's investigation notes and internal audit conducted by the corporate office of Revera Long Term Care Inc. was initiated in two phases on two identified dates. The audit indicated withdrawals was not validly supported as the withdrawal receipts provided were not signed by the resident authorizing the withdrawal.

Review of the internal audit, Appendix B-Unsupported Resident's Trust Account Disbursements for 2019 indicated identified amounts related to total withdrawals, withdrawal receipt or support provided and unsupported amounts for resident #001, #002, #003, #004, #005, #006 and 12 other residents.

Review of financial record for resident #001 indicated the resident was admitted on an identified date. Review of the trust account history indicated money transactions from an identified period. Review of documented cash withdrawal receipts indicating resident's signature, six receipts were missing.

Review of financial record for resident #002 indicated the resident was admitted on an identified date. Review of the trust account history indicated money transactions from an identified period. Review of documented cash withdrawal receipts indicating resident's signature, two receipts were unsigned by resident #002 on two identified dates. One cash withdrawal receipt was missing.

Review of financial record for resident #003 indicated the resident was admitted on an identified date. Review of the trust account history indicated money transactions from an identified period, with 26 cash withdrawals. Review of documented cash withdrawal receipts indicating resident's signature, 19 receipts were unsigned by resident #003. One cash withdrawal was missing receipt on an identified date.

Review of financial record for resident #004 indicated the resident was admitted on an

identified date. Review of the trust account history indicated money transactions from an identified period, with 10 cash withdrawals. Review of documented cash withdrawal receipts indicating resident’s signature, eight receipts were unsigned by resident #004. One cash withdrawal was missing receipt.

Review of financial record for resident #005 indicated the resident was admitted on an identified date. Review of the trust account history indicated money transactions from an identified period with 13 cash withdrawals. Review of documented cash withdrawal receipts indicating resident’s signature,12 receipts were unsigned by resident #005, from two identified months.

Review of financial record for resident #006 indicated the resident was admitted on an identified date. Review of the trust account history indicated money transactions from an identified period with 21 cash withdrawals. Review of documented cash withdrawal receipts indicating resident’s signature, 18 receipts were unsigned by resident #006, for various identified months with three missing receipts.

The home failed to provide to the inspectors documented deposit receipts for the period reviewed.

In an interview staff member #101 stated when residents requested cash withdrawals the amount would be checked for available funds, would then be entered into PointClickCare (PCC) a receipt would be printed from PCC, a copy was provided to the resident then kept on the file monthly. Once the receipt was signed by the resident it would be filed into a binder for the home’s records. Deposits of cash or cheques by the resident they would receive a receipt from the receipt book not PCC. A duplicate receipt would be provided to the residents with each individual name with the amount. At the time of the monthly statements they copied the cheques and wrote cash if it was cash and the family would get a duplicate copy from the receipt book. The staff member #101 further indicated they did not obtain authorizations from the residents for all the cash withdrawals from the residents' Trust accounts and did obtain signatures for the receipts from the residents for the cash withdrawals. Staff member #101 had access to the residents' trust funds with the Executive Director (ED), staff member #101 admitted withdrawing monies from residents trust accounts for their personal use.

In an interview ED #102 indicated the home’s process when a resident request money from their trust account they have a petty cash receipt sign off sheet for them to sign and the next day staff member #101 prints the receipt from PointClickCare (PCC) and

attaches to the petty cash sign off sheet. The home's process for money and cheque deposits there is a book which comes from Revera which says Fosterbrooke, it's an account book, staff member #101 would make a batch entry for the amounts to be deposited to the bank, there is a slip which goes with the cheques with an area to record cash deposits,  the bank stamps confirmation for the deposits and this record is attached to the batch sheets. The ED acknowledged this was not completed, they had no records of the residents receiving cash withdrawals as identified from the internal audit and no receipts for deposits for the residents into their trust accounts. The ED further stated in the, meeting with the residents and their families of Fosterbrooke they confirmed that they did not receive receipts for funds withdrawn and funds deposited to the Trust accounts.

The licensee failed to ensure that a receipt is provided to the resident or a person acting on behalf of a resident for all money received and deposited into a trust account. [s. 241. (7) (a)]

3. The licensee has failed to ensure that quarterly itemized statements are provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident, that include:
• deposits
• withdrawals, and
• the balance of the resident's funds as of the date of the statement

The home submitted a CIS report to the Ministry of Long-Term Care, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified residents trust accounts had withdrawals with no description of how the money was to be used.

A review of the home's investigation notes and internal audit conducted by the corporate office of Revera Long Term Care Inc. was initiated in two phases on two identified dates. The audit indicated the management at the Home could not confirm whether trust statements were mailed out to residents and or substitute decision maker (SDM) on a monthly basis as required by Company procedures. The audit indicated that residents or SDMs would have raised concerns if they had received the trust statements and seen the volume and value of transactions going through the accounts.

Review of the monthly itemized statements provided to the inspectors for residents #001, #002, #003, #004, #005, and #006 did not indicate copies of the statements were provided to the residents or SDMs. Review of the resident's financial records did not

reveal that the resident or SDMs were provided a copy of the itemized trust statements.

In an interview staff member #101 indicated they printed the monthly itemized trust statements which included hairdressing, activities, deposits, cash withdrawals, tuck shop or gift shop purchases and footcare. Staff member #101 acknowledged the itemized trust statements were not provided to the residents, or persons acting on behalf of a resident on a monthly basis.

In an interview ED #102 indicated residents or SDMs are to receive monthly trust account statements indicating deposits and withdrawals. The ED further stated in the, meeting with the residents and families of Fosterbrooke they confirmed that they did not receive monthly or every other month Trust account statements as indicated by the staff member #101.

The licensee failed to ensure that quarterly itemized statements are provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident. [s. 241. (7) (f)]

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

The home submitted a CIS report to the Ministry of Long-Term Care, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified residents trust accounts had withdrawals with no description of how the money was to be used.

A review of resident's business files was carried out for resident #001, #002, #003, #004, #005 and #006, no trust account written authorization forms were found for the residents or person acting on behalf of the resident in the resident business files.

In an interview staff member #101 indicated they had not received written authorization from the residents or person acting on behalf of the residents when setting up the trust accounts at the home.

In an interview ED #102 indicated that upon admission if a resident or family is interested in setting up a trust account at the home, a trust agreement form is signed authorizing

the trust account and withdrawals. The ED further indicated and acknowledged that resident #001, #002, #003, #004, #005 and #006 had trust accounts set up at the home and was aware that written authorization was not received from resident #001, #002, #005, #006 and Substitute Decision Maker (SDM) authorization on behalf of resident #003 and #004 when setting up the trust accounts at the home.

The licensee has failed to ensure that written authorization is received from the resident, or a person acting on behalf of the resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account, 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. [s. 241. (8)]

5. The licensee has failed to ensure that authorized withdrawals had been included in the quarterly itemized statements.

The home submitted a CIS report to the Ministry of Long-Term Care, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified residents trust accounts had withdrawals with no description of how the money was to be used.

A review of the home’s investigation notes and internal audit conducted by the corporate office of Revera Long Term Care Inc. was initiated in two phases on two identified dates. The audit indicated that resident #001, #002, #003, #004, #005 and #006 had significant cash withdrawals from their trust accounts. For these residents, their Ontario Disability Support Program (ODSP) and pension cheques were deposited in the trust account by staff member #101 and cash withdrawals were processed without consistently making payments to their maintenance accounts.

In 2019, resident #001, #002, #003, #004, #005, #006 and 12 other residents had identified amounts of unsupported funds withdrawan from there accounts.

A review period from an identified period of the home’s trust transaction report from PCC for withdrawals was carried out for resident #001, #002, #003, #004, #005 and #006 and indicated the following:

-Resident #001 had 16 withdrawal transactions, with ten receipts signed by resident and staff member #101, five missing receipts and 1 receipt with no signatures.
-Resident #002 had 24 withdrawal transactions, with 20 receipts signed by the resident’s SDM and staff member #101, with one missing receipt and three receipts with no

signatures.
-Resident #003 had 26 withdrawal transactions, with six signed receipts by the resident and staff member #101, one missing receipt and 19 receipts with no signatures.
-Resident #004 had ten withdrawal transactions, with one signed receipt by the resident and staff member #101, one missing receipt and eight receipts with no signatures.
-Resident #005 had 13 withdrawal transactions, with one signed receipt by the resident and staff member #101 and 12 receipts with missing signatures.
-Resident #006 had 21 cash withdrawals, with two receipts signed only by staff member #101, three missing receipts and with 16 receipts with no signatures.

In an interview, staff member #101 indicated when a resident would request a withdrawal of money, the resident trust account would be checked by the staff member #101 to see if the requested funds were available, they would then provide the resident with the requested amount of money, the receipt would be printed and signed by both staff member #101 and the resident and it would then be filed into a binder. Staff member #101 further indicated that if a resident could not sign, the SDM or a manager could sign on their behalf. Inspector #746 and Inspector #644 listed out the withdrawal amounts as noted in the audit for resident #001, #002, #003, #004, #005 and #006, staff member #101 confirmed and acknowledged that they withdrew funds from the resident’s trust accounts without authorization for personal use.

In an interview, ED #102 acknowledged that the above mentioned withdrawals listed in the statements were unauthorized by the staff member #101.

The licensee failed to ensure that the authorized withdrawals have been included in the quarterly itemized statements. [s. 241. (9)]

**Issued on this 7th day of July, 2020**

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

**Original report signed by the inspector.**

Ontario

| Ministry of Long-Term Care | Ministère des Soins de longue durée |
|---|---|
| **Order(s) of the Inspector** | **Ordre(s) de l'inspecteur** |
| Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 | 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 Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | AMANDEEP BHELA (746), ANGIEM KING (644) |
| **Inspection No. / No de l'inspection :** | 2020_594746_0004 |
| **Log No. / No de registre :** | 000518-20 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 22, 2020 |
| **Licensee / Titulaire de permis :** | Revera Long Term Care Inc.<br>5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4 |
| **LTC Home / Foyer de SLD :** | Fosterbrooke<br>330 King Street West, NEWCASTLE, ON, L1B-1G9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Charlene Smith |

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

**Order # / No d'ordre :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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 LTCHA.

Specifically, the licensee shall:

1. Complete a review of the home's Financial policy (Resident Trust Accounts, FIN2- 060.01, revised 1/18) related to resident Trust accounts with the applicable parties responsible for managing resident Trust Accounts.

2. Develop an auditing process to ensure there is no misappropriation or misuse of resident funds or funds held in Trust.

3. The auditing process must also include components identified in the home's financial policy related to SDM involvement when setting up a Trust account, appropriate signatures are obtained for any withdrawals, receipts provided, and statements made available.

4. Documentation of all audits must be kept and available upon inspector request.

**Grounds / Motifs :**

1. The licensee failed to ensure that resident #001, #002, #003, #004, #005 and #006 were protected from financial abuse.

"Abuse"- definition:
2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "financial abuse" means any misappropriation or misuse of a resident's money or property. O.Reg.79/10 s.2(1).

The home submitted a Critical Incident Report (CIS) report to the Ministry of Long-Term Care, which stated that resident #001, #002, #003, #004, #005, #006 and 10 other identified resident trust accounts had withdrawals with no description of how the money was to be used.

A review of the home's financial audits and investigation records indicated the home has one trust account held at a financial institution managed by staff member #101. The statements for three identified months were reviewed. Cheques were drawn on the account at different times in the year resulting in the account being overdrawn and overdraft charges applied by the bank. The audit report further indicated in an identified year, that 132 cheques were cleared from the bank account. One hundred and twenty-four of these cheques had staff member #101 as the payee. The other eight cheques were issued to the home as payment for resident's maintenance/accommodation bills. The audit further indicated that resident #001, #002, #003, #004, #005 and #006 had significant cash withdrawals from their trust accounts. For these residents, their Ontario Disability Support Program (ODSP) and pension cheques were deposited in the trust account by staff member #101 and cash withdrawals were processed by staff member #101.

A review period for an identified time period of the home’s trust transaction report from Point Click Care (PCC) for withdrawals was carried out for resident #001, #002, #003, #004, #005 and #006 indicated the following:

-Resident #001 had 16 withdrawal transactions, with ten receipts signed by the resident and staff member #101, five missing receipts and one receipt with no signatures.
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-Resident #003 had 26 withdrawal transactions, with six signed receipts by the resident and staff member #101, one missing receipt and 19 receipts with no signatures.
-Resident #004 had ten withdrawal transactions, with one signed receipt by the resident and staff member #101, one missing receipt and eight receipts with no signatures.

-Resident #005 had 13 withdrawal transactions, with one signed receipt by the resident and staff member #101 and 12 receipts with missing signatures.
-Resident #006 had 21 cash withdrawals, with two receipts signed only by staff member #101, three missing receipts and with 16 receipts with no signatures.

In an interview staff member #101 indicated they had withdrawn the cash from the residents trust account in amounts that had overdrawn on the account which resulted in overdraft charges. The overdraft charges were not replaced back into the trust account. Inspector #746 and Inspector #644 listed out the withdrawal amounts as noted in the audit for resident #001, #002, #003, #004, #005 and #006, staff member #101 confirmed and acknowledged that they withdrew funds from the resident's trust accounts without authorization for personal use. The staff member #101 acknowledged that they had financially abused residents #001, #002, #003, #004, #005 and #006.

In an interview Executive Director (ED) acknowledged resident trust accounts held at a financial institution were overdrawn which resulted in bank charges to the affected residents. The ED further indicated they were not aware of the overdraft until after the internal audit was completed by Corporate, the ED acknowledged there were areas of the trust account policy that the home failed to maintain. The ED indicated that the police were notified on an identified date about the incident, and file was forwarded to the Police Financial Crimes unit for investigation. The ED was advised that in the event a forensic audit report is identified to suggest a crime offence(s) has or have occurred to contact the police.  The ED acknowledged that the licensee failed to ensure that resident #001, #002, #003, #004, #005 and #006 were protected from financial abuse from staff member #101.

The licensee has failed to ensure that resident #001, #002, #003, #004, #005 and #006 were protected from financial. From an identified time period, staff member #101 was able to withdraw frequent and large sums of money from resident trust accounts. The licensee failed to comply with their own internal financial policies, by way of not having two signatures for withdrawals, causing resident trust accounts to receive overdraft charges due to the large amounts of withdrawals, failing to provide copies of itemized trust statements to residents or SDMs, failing in obtaining written authorization forms from resident's or SDMs upon setting up a trust account and failing to include unauthorized withdrawals in

the quarterly itemized statements.
(746)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 02, 2020

## 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 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 22nd day of June, 2020**

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

**Name of Inspector / Nom de l'inspecteur :** Amandeep Bhela

**Service Area Office / Bureau régional de services :** Central East Service Area Office