Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 14, 2021	2021_747725_0034	010870-21, 011682-21, 012167-21, 012437-21, 012561-21, 012941-21	Critical Incident System

Licensee/Titulaire de permis

DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Franklin Gardens Long Term Care Home
24 Franklin Road Leamington ON N8H 4B7

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

CASSANDRA TAYLOR (725), DEBRA CHURCHER (670)

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): September 28, 29, October 1,4,5,6 and 7, 2021.

This inspection was conducted concurrently with Complaint inspection #2021_747725_0033.

During the course of this inspection the following intakes were inspected;
Log # 011682-21 - Follow-up to CO#001 from inspection #2021_747725_0023 / 006846-21 regarding r. 8. (1), CDD Aug 16, 2021
Log # 012941-21 - Follow-up to CO#002 from inspection #2021_747725_0024 / 006427-21, 008214-21 regarding r. 52. (2), CDD Aug 16, 2021
Log # 012167-21/ CIS 2602-000012-21 - relating to falls prevention and management
Log # 012437-21/ CIS 2602-000013-21 - relating to falls prevention and management
Log # 010870-21 /CIS 2602-000011-21 - relating to administration of glucagon
Log # 012561-21/ CIS 2602-000014-21 - relating to alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse, four Registered Practical Nurses, seven Personal Support Workers and one Social Worker.

During the course of this inspection the inspector(s) also conducted observations, record review relevant to the inspection and interviewed residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 52. (2)	CO #002	2021_747725_0024	725
O.Reg 79/10 s. 8. (1)	CO #001	2021_747725_0023	670

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with their prevention of abuse and neglect policy.

It was noted during record review that resident #008 had three documented incidents of potential abuse with resident #009. The incidents occurred on three separate occasions, where they were separated as a result. During further review no Critical Incident System (CIS) report was documented for the three incidents. During record review for resident #009 no documentation relating to an assessment post incident was documented. During an interview with the Administrator it was confirmed that the incidents were not reported or further investigated.

The homes policy titled (Zero Tolerance to Resident Abuse and Neglect) outlined the procedure to prevent abuse and neglect;
-Separate the resident from alleged abuser,
-Notify the Director via the Ministry of Long Term Care,
-Immediately inform Resident's family/substitute decision maker (SDM),
-Notify the required persons in the home/licensee,
-Notify the police
-The RN shall assess the victim and chart/record any and all findings etc.

By not following the prevention of abuse and neglect policy the incidents were not further investigated, potential support was not provided to the alleged victim, the Director was not notified nor were the Power of Attorneys (POA).

Sources: Resident #008 and #009's records, staff interviews and the homes policy and procedure – 02-01-02 **-** "Zero Tolerance to Resident Abuse and Neglect". [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is compliant with their prevention of abuse and neglect policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A) Review of a residents clinical record showed that the resident experienced a fall resulting in an injury and transfer to the hospital . Upon return to the home the resident was referred to services, and required additional assessments and treatments.

B) Review of a residents clinical record showed that the resident experienced another fall resulting in injury that required transfer to the hospital. Upon return to the home the resident was referred to services, and required additional assessments and treatments.

The Inspector was unable to locate a Critical Incident System (CIS) report for the dates of the incidents.

During an interview with Administrator they acknowledged that a CIS report had not been submitted for either incident.

Failure to complete the required CIS reports placed the resident at risk.

Sources: Resident clinical records, interview with Administrator #110. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is notified no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that different approaches were considered in the revision of the plan of care for a resident.

The resident was known to have increased behaviours during a specific time frame. During that time interventions were put in place however, incidents continued without a revision of the plan of care.

Not re-evaluating the plan of care placed the resident at risk for continued behaviours.

Sources: Resident's records and staff interviews. [s. 6. (10) (c)]

Issued on this 20th day of October, 2021

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

Original report signed by the inspector.