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 sous la Loi de 2007 sur 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 15, 2016	2016_257518_0028	019601-16	Resident Quality Inspection

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

ALISON FALKINGHAM (518), CAROLEE MILLINER (144), SANDRA FYSH (190)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 4, 5, 6, 7, 8, 11, 12 and 13, 2016

The following intakes were completed within the RQI:
032717-15 Critical Incident 2602-000032-15 related to allegations of abuse
029238-15 Critical Incident 2602-000027-15 related to improper care
003576-15 Critical Incident 2602-000002-16 related to allegations of abuse
010316-16 Critical Incident 2602-000006-16 related to allegations of abuse

018295-16 Critical Incident 2602-000014-16 related to allegations of abuse
018509-16 Critical Incident 2602-000015-16 related to allegations of abuse
018474-16 Critical Incident 2602-000003-16 related to falls
019549-16 Critical Incident 2602-000008-16 related to falls
019558-16 Critical Incident 2602-000009-16 related to falls
005886-15 Critical Incident 2602-000009-15 related to allegations of abuse
015170-16 Critical Incident 2602-000013-16 related to falls
034889-15 Critical Incident 2602-000034-15 related to falls
025405-15 Critical Incident 2602-000020-15 related to an unexpected death
025583-15 Critical Incident 2602-000022-15 related to resident elopement
020513-16 Critical Incident 2602-000017-16 related to allegations of abuse
The following intakes were inspected at the same time as the RQI and can be found in a separate report:
008918-15 Complaint IL 008918-15 related to wound care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Assistant Director of Care(ADOC), eight Registered Nurses(RN), two Registered Practical Nurses(RPN), seven Personal Support Workers(PSW), three Health Care Aides(HCA), four Nurses' Aides(NA), one Food Services Supervisor, two Food Service Workers(FSW), one Life Enrichment Director, two Physiotherapy Assistants, the Building Services Supervisor, two Laundry/Housekeeping Aides(HKA), the Maintenance Supervisor, one Activity/Recreation Therapy Aide and the Director of Programs and Support Services. The inspectors completed a tour of the home, observed two meal services, one medication administration, recreation and activity programs and general staff to resident interactions as well as interviewed forty residents or substitute decision makers(SDM), reviewed forty clinical records and the homes policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that residents are protected from abuse by anyone and not neglected by the licensee or staff in the home.

During the Resident Quality Inspection a resident's clinical record was reviewed and it revealed:

One documented incident of suspected resident abuse
Three documented incidents of witnessed resident abuse
One documented incident of a resident self reporting abuse

Review of these incidents revealed that one resident called out indicating possible distress, three residents were cognitively and physically impaired and one resident self reported an incident of abuse. Two critical incidents were submitted to the Ministry of Health and Long Term Care by the home regarding abuse of two additional residents by the indicated resident.

Review of the home's policy indicated:
Abuse Policy-Resident last revised July 2015
Purpose
-to ensure the persons' right to a safe and secure environment
Definition of Abuse
Sexual Abuse
Constitutes any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a licensee staff member.

A resident's care plan was reviewed and it stated the goals were to reduce the incidents of abusive behaviour and interventions were set out for the staff to follow.

Interviews conducted with three Registered Nurses'(RN), three Personal Support Worker (PSW) and a Program Director indicated that the resident tends to display these behaviours at certain times, in certain places and over many months.

The resident was seen by a physician on four occasions and the physician documented the behaviours in the physician's notes .

The licensee failed to protect five residents from a resident's ongoing responsive behaviour. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 had failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.
2. Abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident.

During the Resident Quality Inspection a resident's clinical record was reviewed and it revealed documentation of five unreported incidents of alleged, suspected or witnessed abuse of a resident and two incidents of alleged abuse of a resident reported to the Ministry of Health and Long Term Care.

Interviews with four RN's, three PSW and one Housekeeper stated that they had been aware of this residents abusive behaviours for many months and that these incidents had been reported to the charge nurses.
The four RN's interviewed stated that all documentation goes into shift report given verbally to the oncoming shift, is transmitted shift to shift verbally as well as this documentation would appear on the daily shift report which is reviewed in the morning by the nursing staff and management team during weekdays in the morning team meeting.
There was an internal incident report form available which was not completed for the above mentioned incidents.

Review of the home's policy indicated:
Abuse Policy-Resident last revised July 2015
Investigation Procedure
1. Upon receiving a complaint written or verbal, and/or witnessing an incident of abuse the individual shall immediately report it to their supervisor and/or a member of the management team as this is a mandatory reporting requirement of the Ministry of Health.
2. It is the responsibility of the supervisor and/or the member of the management team to report all incidents pertaining to a suspected/alleged/witnessed abuse to the administrator immediately following the initial reporting of.

The Administrator and DOC said that all alleged/suspected or witnessed incidents of abuse should have been reported to the Director immediately and documented by the charge nurse who first knew of the incidents. [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 to ensure that a person who has reasonable grounds to suspect 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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that, for each resident demonstrating responsive behaviour, the behavioural triggers for the resident are identified.

During the Resident Quality Inspection a resident's clinical record was reviewed and it revealed documentation of inappropriate behaviour which occurred generally on a specific shift and in two specified areas.

Review of the resident's care plan indicated a specific behavioural issue, the goals were to reduce the incidents of this behaviour and promote safety for all residents however the plan did not mention the specific time of day these behaviours occurred, the specific areas this behaviour occurred in and did not set out any form of monitoring of the resident.

The home's policy:
Responsive Behaviour Management last revised April 2014 states:
Purpose:
The plan of care is to be based on assessment that includes:
-mood and behaviour patterns
-wandering
-identified responsive behaviours
-potential behavioural triggers
-variations in resident functioning at different times of the day

Interviews with three RN's, three PSW's and a Program Director confirmed the specific times of day and places when the resident is most likely to display their behaviour.

Interview with a staff member indicated that there was a behaviour board posted in the nursing staff room which was available for all staff to keep informed about the most challenging behaviours in the building and it set out the interventions to be considered. When observed the behaviour board did not contain the indicated resident's name, behaviours, interventions, goal, monitoring or triggers. When asked by Inspector why the resident was not included on the board she stated she was unsure but confirmed that due to the behaviours the resident should be included on the board for all staff to receive information and that the triggers for the responsive behaviour should be included in the care plan as well as placed on the behaviour board. [s. 53. (4) (a)]

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Issued on this 19th day of July, 2016

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

Original report signed by the inspector.