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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 7, 2017	2017_418615_0015	009948-17	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

HELENE DESABRAIS (615), CAROLEE MILLINER (144)

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): May 29, 30, 31 and June 1, 2017.

The following intakes were completed during this inspection:
034938-16/2602-000042-16, Critical Incident related to Medication Management,
031145-16/2602-000029-16, Critical Incident related to Medication Management,
021881-16/2602-000020-16, Critical Incident related to Prevention of abuse,
033379-16/2602-000038-16, Critical Incident related to Prevention of abuse.

Inspectors also toured the residents home areas and common areas, spa rooms, observed resident care provision, resident/staff interactions, medication administration and storage areas, reviewed relevant clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general cleaning of the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant DOC/Infection Control Nurse (ADOC-ICN), the Director of Building Services and Safe Home (DBSSH), the Director of Programs and Support Services (DPSS), two Registered Nurses (RNs), four Registered Practical Nurses (RPNs), 12 Personal Support Workers (PSWs), over 20 residents and three family members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council

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

1 WN(s)
1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

On a specific date, several residents that lived on one area of the home exhibited signs and symptoms of an infection.

On the same day, the Public Health Unit declared that the home was in an outbreak and the residents with symptoms were added to the home's infection line list. The resident names remained on the home's infection line list two days later.

During an interview, the ADOC-ICN shared that registered staff documented affected resident's symptoms of infection on each shift in the progress note section of the point click care (PCC) electronic program until their symptoms had resolved.

During an interview, the DOC and the Inspector reviewed the progress notes of the residents included on the home's infection line listing on a specific date.

The review indicated that staff did not record the infection symptoms for these residents on different shifts and on two specific dates.

The DOC stated that it was the home's expectation that registered staff would document on each shift, the status of residents included on the infection line list that had been affected by the outbreak.

The licensee failed to ensure that staff on every shift recorded symptoms of infection in several residents.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 229. (5) (b)]

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 staff on every shift records symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

Issued on this 20th day of June, 2017

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

Original report signed by the inspector.