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
Jun 29, 2017	2017_508137_0013	022408-16, 023506-16, 029345-16, 029843-16, 035052-16, 001456-17, 001673-17, 002411-17, 002691-17, 002829-17, 003719-17, 004252-17, 004382-17, 008441-17, 009000-17	Critical Incident System

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

MARIAN MACDONALD (137), NATALIE MORONEY (610), SHERRI COOK (633)

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): June 26 - 28, 2017

The following Critical Incident System (CIS) reports were completed during this inspection:

Transferring and Positioning
CIS 2602-000006-17 / Log # 002829-17

Falls Prevention
CIS 2602-000002-17 / Log # 001673-17
CIS 2602-000004-17 / Log # 002411-17
CIS 2602-000007-17 / Log # 003719-17
CIS 2602-000009-17 / Log # 004382-17
CIS 2602-000014-17 / Log # 008441-17

Resident to Resident Abuse
CIS 2602-000022-16 / Log # 022408-16
CIS 2602-000024-16 / Log # 023506-16
CIS 2602-000026-16 / Log # 029345-16
CIS 2602-000026-16 / Log # 029843-16
CIS 2602-000043-16 / Log # 035052-16
CIS 2602-000001-17 / Log # 001456-17
CIS 2602-000005-17 / Log # 002691-17
CIS 2602-000010-17 / Log # 004252-17
CIS 2602-000016-17 / Log # 009000-17

A separate complaint inspection, IL-51155-LO under Log # 010979-17, was also conducted related to emergency plans, staffing and sexual abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director Of Care, Life Enrichment Director, Director of Program and Support Services, one Registered Nurse (RN), six Registered Practical Nurses (RPN), six Personal Support Workers (PSW) and twelve residents.

The Inspectors also observed resident care provision, meal service, resident/staff interactions, reviewed residents' clinical records, internal investigative records, education/training records and relevant policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 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. 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 failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or a risk of harm to the resident had occurred, shall immediately report that suspicion and the information upon which it was based to the Director.

The Abuse Policy, revised July 2016, stated in part that "the Administrator or delegate shall contact the Ministry of Health Long Term Care (MOHLTC) immediately, after being informed of the initial reporting of an actual or alleged incident of abuse and the Supervisor would ensure that the Critical Incident Report (CIS) would be completed and submitted to the MOHLTC with in the 10 business days".

A review of four Critical Incident System (CIS) reports showed that the licensee did not immediately report to the Director, after being informed of alleged and actual incidents of abuse. The MOHLTC after hours pager was also not contacted.

During an interview, the Director of Care #101 (DOC) said that the policy and expectation of the home was to immediately inform the Director of the CIS regarding abuse and had failed to do so.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or a risk of harm to the resident had occurred, shall immediately report that suspicion and the information upon which it was based to the Director. [s. 24. (1) 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 to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, shall immediately reported that suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report, was submitted related to an incident where an identified resident sustained an injury while being transferred, by two Personal Support Workers (PSW).

An interview with the Director of Care # 101 (DOC) and the Administrator # 106, a review of internal investigative records and resident clinical records showed that the resident required a specific transfer device however, a different technique was completed
The DOC and Administrator said the PSW's did not follow the home's policy and did not use proper transferring techniques, when assisting an identified resident, which resulted in an injury and a significant change in the resident's condition. [s. 36.]

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 used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 5th day of July, 2017

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

Original report signed by the inspector.