



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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 9, 10, 12, 2011	2011_067171_0013	Complaint

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

ELISA WILSON (171)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of nursing, RAI Coordinator, foodservices manager, registered dietitian, registered staff, health care aides, dietary aides, cooks and residents.

During the course of the inspection, the inspector(s) observed lunch and dinner service on August 9, 2011 and breakfast service on August 10, 2011. The inspector reviewed plans of care for select residents. Also reviewed minutes of the residents' council meetings and selected Home policies.

The following Inspection Protocols were used in part or in whole during this inspection:

- Dining Observation
- Food Quality
- Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Définitions 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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

- (a) the planned care for the resident;**
- (b) the goals the care is intended to achieve; and**
- (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits sayants :

1. Different approaches are not always considered when care set out in the care plan has not been effective. Different approaches have not been considered in the plan of care for an identified resident regarding blood glucose control. The goal set out in the nutrition care plan indicated maintaining a certain blood glucose level, however the actual blood glucose levels have consistently been out of this goal range. There were a number of physician notes regarding adjusting insulin and medications however there were no assessments or different approaches considered in the documentation regarding nutritional intake.

[LTCHA, 2007 S.O.2007, c.8 s.6(11)(b)]

2. Clear direction was not always provided for the staff and others who provide direct care to the resident. An identified resident was on a restricted diet. There was no direction documented regarding who would track the restricted nutrient to ensure the resident was provided the appropriate amount. There was no direction provided for staff on the food/fluid sheets indicating the exceptions to regular serving sizes. The plan as set out by the dietitian was not clear regarding after dinner nourishment and what items were to be provided.

[LTCHA, 2007 S.O.2007, c.8, s.6(1)(c)]

3. The care specified in the Nutrition section of the plan of care was not provided to an identified resident. This resident's plan of care indicated the resident was to be on a restricted diet, however a review of the food and fluid records indicated an intake of more than the specified restriction on numerous days within the past three months.

[LTCHA, 2007, S.O. 2007, c.8, s.6(7)]

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 care is provided to the residents as specified in the plan of care, to ensure clear direction is provided to staff who provide direct care to the resident and that different approaches are considered when care set out in the care plan is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

- s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
 4. Monitoring of all residents during meals.
 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
 6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
 7. Sufficient time for every resident to eat at his or her own pace.
 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits sayants :

1. Personal assistance was not provided at meal times to assist an identified resident to eat and drink independently. On August 9, 2011 at lunch the resident was served dessert but the spoon was set out of reach. On August 9, 2011 at dinner the resident's juice and water were set on the table out of reach. These fluids were never moved closer to the resident during the meal service.
[O.Reg. 79/10, s.73(1)9.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

- s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
- (a) the nature of each verbal or written complaint;
 - (b) the date the complaint was received;
 - (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
 - (d) the final resolution, if any;
 - (e) every date on which any response was provided to the complainant and a description of the response; and
 - (f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits sayants :



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1. Not all complaints received by the Home are fully documented with all of the details required by this Regulation. There are a number of food or foodservice related complaints that are brought forward at the residents' council meetings. Not all issues brought forward include documentation regarding the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required. There is no documentation regarding the final resolution, the dates any responses were provided to the complainant and any response made in turn by the complainant. [O.Reg. 79/10, s.101(2)(c)(d)(e)(f)]

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 all details required by the legislation are documented regarding complaints and responses to complaints, to be implemented voluntarily.

Issued on this 17th day of August, 2011

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

A handwritten signature in cursive script that reads "Elisa Wilson". The signature is written in black ink on a white background within a rectangular box.