

**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**London Service Area Office  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 20, 2020	2020_777731_0020	016780-20, 017021-20	Critical Incident System

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**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**

KRISTEN MURRAY (731)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): October 13, 14, and 15, 2020.**

**The following Critical Incident intakes were completed within this inspection:**

**Related to falls prevention**

**Critical Incident Log #016780-20 / CI 2602-000017-20**

**Critical Incident Log #017021-20 / CI 2602-000018-20**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Restorative Manager, Registered Nurses (RNs), a Registered Practical Nurse (RPN), a Personal Support Worker (PSW), and residents.**

**The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.**

**The following Inspection Protocols were used during this inspection:  
Falls Prevention**

**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**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the policy related to head injury routine as part of the home's falls management program was complied with, for a resident.

O. Reg. 79/10 s. 48 (1) requires the home to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's policy and procedure "Head Injury Routine", number "05-04-02".

The head injury routine (HIR) policy required staff to initiate HIR immediately after a fall was sustained by a resident where the resident actually or potentially may have sustained an injury to their head and the resident could not clearly confirm if they had hit their head.

A resident sustained unwitnessed falls on three separate dates. The HIR for the resident was not documented for each of the three falls. The resident was not able to tell staff if they hit their head. A Registered Nurse (RN) confirmed that HIR should have been completed for the unwitnessed falls sustained by the resident. There was increased risk to the resident related to the HIR not documented.

Sources: "Head Injury Routine" policy #05-04-02; a resident's progress notes, assessments, and paper chart; and interviews with a RN and other staff. [s. 8. (1) (a), s. 8. (1) (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 the policy related to head injury routine as part of the home's falls management program is complied with, to be implemented voluntarily.***

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**Issued on this 26th day of October, 2020**

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

**Original report signed by the inspector.**