Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 6, 2023

Inspection Number: 2023-1113-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: 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.

Long Term Care Home and City: Franklin Gardens Long Term Care Home, Leamington

Lead Inspector	**Inspector Digital Signature**
Terri Daly (115)	Terri Daly Digitally signed by Terri Daly Date: 2023.03.10 12:58:15 -05'00'

Additional Inspector(s)
Julie DAlessandro (739)

INSPECTION SUMMARY

The inspection occurred on the following date(s): January 26, 27, 30 and February 2, 2023.

The following intake(s) were inspected:
- Intake: #00002118, CI#: 2602-000014-22 fall with injury.
- Intake: #00002599, CI#: 2602-000012-22 resident to resident abuse.
- Intake: #00017665, CI#: 2602-000002-23 fall with injury.
- Intake: #00019915, CI#: 2602-000006-23 alleged resident to resident abuse.
- Intake: #00008590 Complaint concerns related to housekeeping, pest control and meal service.
- Intake: #00008632 Complaint concerns related to housekeeping and alleged resident to resident abuse.
- Intake: #00014917 Complaint concerns related to alleged resident to resident abuse.

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

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure that an allegation of abuse that was reported to the licensee was reported to the Director after the results of the investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), following the investigation completed by the home.

RATIONALE AND SUMMARY
Complaints were received by the Ministry of Long-Term Care (MLTC) on specific dates, which detailed concerns related to alleged abuse between two residents.

A review of the residents' progress notes indicated that the two residents' had a consensual relationship during a specific time span. On a specific date one of the residents' expressed concerns to the home's Social Worker (SW) about the relationship.

During an interview with the SW they indicated that initially they did not feel that this incident would have been reportable to the MLTC, however after a review of the definitions and legislation they believed that there was a risk of harm and that this should have been reported through the Critical Incident System (CIS).

During an interview with one of the residents, they told the inspector that they were forced to be involved with another resident, but could not recall the date.

A review of the home's policy #RC 02-01-02 titled Zero Tolerance to Resident Abuse and Neglect, last reviewed December 22, 2022, indicated;
This is the UniversalCare and Home's policy and procedures to determine whether a report to the Ministry of Long-Term Care Director is required under legislation in response to an alleged, suspected or witnessed incident of abuse or neglect of a resident.

The Administrator and/or Director of Care/Designate will contact the Ministry Long Term Care and report the abuse or alleged abuse to the Director. The reporting is via Critical Incident System (CIS) during regular weekdays hours; after hours and during weekend and statutory holiday days, report using the Service Ontario phone number (1-888-999-6973 Service Ontario), then complete the Critical Incident (CI).

During an interview with the Administrator and the Director of Care, with review of the legislation and regulations related to alleged abuse, the Administrator stated that they could see why they should have submitted a CI that would have included the actions the home took to keep the resident safe from alleged abuse.

The home later submitted a Critical Incident reporting the allegation of abuse between the two residents.

SOURCES
Resident's clinical records, interviews and the home's Zero Tolerance to Resident Abuse and Neglect policy and procedure.
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