



**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**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 9, 2013	2013_217137_0018	L-000429-13	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)

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): August 8, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Quality Improvement Nurse, Office Manager, Maintenance Person, Receptionist, Physiotherapist, Physiotherapy Aide, two Registered Practical Nurses, one Housekeeper, one Personal Support Worker and three Health Care Aides.

During the course of the inspection, the inspector(s) observed resident, posting of required information, reviewed internal investigative reports, resident's clinical records, Resident Abuse policy and staff training records, related to resident abuse.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. There is no documented evidence that the appropriate police force was immediately notified of an incident of abuse of a resident.

The Director of Care and Quality Improvement Nurse confirmed that the police were not notified of the incident. [s. 98.]

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 the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.



WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

3. Actions taken in response to the incident, including,

- i. what care was given or action taken as a result of the incident, and by whom,**
- ii. whether a physician or registered nurse in the extended class was contacted,**
- iii. what other authorities were contacted about the incident, if any,**
- iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and**
- v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).**

Findings/Faits saillants :

1. There is no documented evidence that the Critical Incident report, submitted to the Director, had been amended to include the outcome or current status of the individual or individuals who were involved in the incident.

The Director of Care confirmed that the Critical Incident report had not been amended.
[s. 104. (1) 3.]

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 report submitted to the Director is complete and includes the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.



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Issued on this 9th day of August, 2013

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

Marian C. Mac Donald