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
Apr 12, 2017	2017_418615_0002	003099-17	Resident Quality Inspection

Licensee/Titulaire de permis

COPPER TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

COPPER TERRACE
91 TECUMSEH ROAD CHATHAM ON N7M 1B3

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

HELENE DESABRAIS (615), ALICIA MARLATT (590), ANDREA DIMENNA (669), NANCY SINCLAIR (537), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 21, 22, 23, 24, 28, and March 1, 2, 3, 2017.

The following intakes were completed during this inspection:
018630-16/IL-45211-LO, Complaint related to Prevention of Abuse and Neglect,
030911-16/IL-47569-LO, Complaint related to Prevention of Abuse and Neglect,
031031-16/1115-000030-16, Critical Incident related to Prevention of Abuse and Neglect,
019428-16/1115-000009-16, Critical Incident related to Falls Prevention,
035160-16/1115-000039-16, Critical Incident related to Falls Prevention,
000867-15/1115-000001-15, Critical Incident related to Falls Prevention,
010950-16/1115-000007-16, Critical Incident related to Medication System Management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Life Enrichment Director, the Food Services Manager, the Office Manager, two Nurse Managers, the Building Services Supervisor, the Registered Practical Nurse (RPN) RAI-Coordinator, one Physiotherapist, one food services staff, one laundry staff, three housekeeping staff, two Registered Nurses (RN), 15 RPNs, 23 Personal Support Workers (PSW), over 40 residents and three family members.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the Infection Prevention and Control program.

During the initial tour of the home of the Resident Quality Inspection, several residents' personal care items were observed to be unlabelled and/or stored improperly.

On six different days, in a sitting lounge on an identified unit, two Inspectors observed an aerosol mask with fingerprints and dried secretions on it and, an aerosol machine sitting on top of books on a table. The aerosol machine and mask were not labelled with a resident's name.

On a specific date, a Nurse Manager and an Inspector observed the unlabelled aerosol machine and mask. The Nurse Manager agreed that there was no name on the items and that these items should be kept either in the resident's room or discarded after each use. The Nurse Manager acknowledged that there was an infection control concern with this personal care item being left out.

On a specific date, in two resident rooms, shared bathroom on an identified unit, an Inspector observed two unlabelled urinals sitting beside the sink.

On two different days, in a resident's room, shared bathroom on an identified unit, an Inspector observed two toothbrushes, a denture cup, toothpaste and a bottle of cream, unlabeled and all sitting on the shared sink vanity.

On a specific date, in a resident's room, shared bathroom on an identified unit, an Inspector observed two unlabelled toothbrushes, one sitting on the vanity and one on the paper towel rack. An Inspector and a Registered Practical Nurse (RPN) observed two unlabelled toothbrushes, one sitting on the vanity and one on the paper towel rack. The RPN shared that the expectation was that all residents' personal care items are to be labelled and stored properly.

On three different dates, in a tub room on an identified unit, two Inspectors observed two nail clippers unlabelled and sitting on the shared vanity.

On a specific date, in a tub room on an identified unit, an Inspector and an RPN observed an opened and used bar of soap, nail clippers with nail clippings sitting on top of the residents' personal items storage bin. The items were both unlabelled. The RPN shared that the expectation was that all resident’s personal care items are to be labelled and stored properly.

During an interview the Director of Nursing (DON) stated that aerosol masks should be

kept in the resident room or discarded after use and that it poses an infection control issue when not stored properly. The DON shared that the expectation was that all residents' personal care items are to be labelled with the resident's name and stored properly for infection prevention and control.

During a medication observation, on an identified resident home area, an Inspector observed an RPN administrating medications to different residents without washing hands in between. The RPN stated that one glucometer is used for all residents and is not disinfected in between residents. The RPN shared that hand washing and disinfecting the glucometer between residents would be an expectation.

Review of the home's "Infection Prevention & Control" Policy under Routine Practices, stated: "Hand hygiene is mandatory before and after all resident care. Examples of hand hygiene must be performed: Before any sterile procedure, Before preparing medications, Before starting work and before leaving the work area, Before direct resident care". "Waste. Contain biomedical waste, (e.g., sponges, dressings or surgical drapes soaked with blood or secretions) in impervious waste-holding bags or double bags".

During an interview, the Administrator and an RPN stated that it is the home's expectation to wash hands in between residents' care during the medication pass and to disinfect the glucometer when using it between residents.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 16, 2015, as a Compliance Order (CO) in a Resident Quality Inspection #2015_257518_0016. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home submitted a Critical Incident System (CIS) report, related to Prevention of Abuse, Neglect and Retaliation, to the Ministry of Health and Long Term Care indicating an incident occurred involving two residents. The family member of a resident submitted a complaint to the Ministry of Health and Long Term Care stating that an incident occurred involving the two residents.

During an interview, a Personal Support Worker (PSW) stated that an incident between the two residents was witnessed.The PSW left the said residents alone for approximately one to two minutes to go get help before intervening. The PSW stated not recalling speaking with the Administrator or Director of Nursing (DON) after the incident, but did speak with a Nurse Manager on the unit the day of the incident.

During an interview, a RPN stated not recalling speaking with any of the Management team about the incident.

Review of the home's "Prevention, Elimination and Reporting of Abuse" Policy & Procedure #2-07, dated November 1, 2013, stated: "Protocol for Investigation Allegations of Resident Abuse by a Resident:The person receiving the initial report shall obtain a detailed account of the incident from the person reporting the incident. Ideally the report shall be as detailed as possible outlining what was seen and heard. The report shall be in the person's own words and signed by the person. The staff member receiving the initial report shall initiate the "Investigation of Allegations of Abuse" form. The staff member receiving the initial report shall ensure that all information is documented in both resident's chart in a chronological order. Information obtained during the investigation will be be documented in writing or tape recorded. If documented in writing the information is to be signed by all parties present during the interviews.", and "Immediate Interventions

following Allegations of Resident Abuse: In all cases of resident abuse, the priority is to ensure resident safety and well being. Witnesses to resident abuse shall immediately intervene and make their presence known to both the resident and perpetrator. The witness shall ensure the safety of the resident(s) and/or seek assistance of staff to do so. In cases of resident to resident abuse staff shall ensure the residents are separated and tended to separately."

During interviews, the DON stated that an internal investigation had been completed, but could not provide documentation to support this. The DON stated that they were not aware of some details that had been discovered during the inspection of this incident. The DON stated that this task was delegated to one of the Nurse Managers to investigate this incident but that staff no longer works at the home. The DON stated that it was the expectation that staff follow the home's policy related to abuse, that an investigation should be completed and documented and that staff should not have left the residents alone before getting help as per the home's policy.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 16, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_257518_0016. [s. 20. (1)]

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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #3: 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:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on the assessment of the resident and the resident's needs and preferences.

During an interview on two different days, a resident stated that their preference for bathing was not offered. During the interview the resident shared what was preferred.

During an interview, a Personal Support Worker (PSW) was unable to identify what the preferences of the resident would be for bathing as it was not clearly identified in the Kardex.

A review of the resident's care plan stated how to bath the resident. No indication of a preference for showers or baths was documented. The resident's RAI-Pre admission data sheet stated what the resident preferred.

During an interview, a Registered Practical Nurse (RPN) reviewed the resident's care plan and was unable to find the resident's preferences for bathing. The RPN stated that it was the expectation that the residents' needs and preferences should be listed in the care plan. [s. 6. (2)]

2. During an interview, a resident stated what was preferred for bathing and the resident had asked staff on several occasions to have what was preferred.

A review of the resident's Plan of Care stated how to assist the resident for bathing. No indication of a preference for showers or baths was documented. The resident's admission note on a specific date, did not mention resident's preferences for bathing.

During an interview, a Personal Support Worker (PSW) stated that the resident's Kardex showed what the resident was to receive, not what the resident preferred.

During an interview, a PSW stated what the resident preferred. The RPN RAI

Cooridinator was unable to locate the resident's 24 hours care plan and unable to locate the RAI-Pre Admission Data sheet identifying the resident's preferences. A review of the Minimum Data Set (MDS) under section AC: Customary Routine stated what the resident prefers.

During an interview, the RAI-Coordinator stated that the residents' choice and preferences should be in the plan of care and in Point of Care (POC) task for the PSWs. The RAI-Coordinator stated that it was the expectation that the residents' needs and preferences should be listed in the care plan.

The licensee has failed to ensure that the plan the care was based on the assessment of the two residents' needs and preferences.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 16, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_257518_0016. [s. 6. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

During a resident interview for Stage 1 of the Resident Quality Inspection, a resident stated what sleep patterns and preferences were preferred.The resident stated that no one asked about sleep patterns or preferences. The resident stated that this preference was brought up to staff many times and they still don't respect the preferences.

Review of the resident's plan of care in Point Click Care (POC) did not include documented evidence of sleep patterns and preferences.

During an interview, the RPN RAI Coordinator, a RPN and a PSW stated that the resident was not assessed for sleep patterns and preferences, that the resident preferences were reported to staff and that the preferred sleep patterns were not in the resident's plan of care. The RAI Coordinator stated that the expectation is that a resident sleep patterns and preferences should be assessed and be part of the plan of care of residents and be respected and promoted by staff.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed by the method of his or her choice.

A review of a resident's care plan stated how to assist the resident for bathing. No indication of a preference for showers or baths was documented. The admission note on a specific date did not mention choices or preferences for bathing. A review of the Minimum Data Set (MDS) under section AC: Customary Routines stated what the resident prefers.

During an interview, the resident stated what was preferred, and resident had asked staff on several occasions to have what was preferred for bathing.

During an interview, a Personal Support Worker (PSW) stated that the resident's Kardex showed what the resident was to receive, not what the resident preferred.

During an interview, a PSW stated what the resident preferred and witnessed the resident not receiving what was preferred for bathing. The RPN RAI Coordinator was unable to locate the resident's 24 hour care plan and unable to locate the RAI-Pre Admission Data sheet for that resident. A review of the Minimum Data Set (MDS) under section AC: Customary Routine stated what the resident prefers.

During an interview, the RAI-Coordinator stated that it was the expectation that the residents' needs and preferences should be fully respected and promoted.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 33. (1)]

2. During an interview, a resident stated stated that a preference for bathing was not offered. During the interview the resident shared what was preferred.

During an interview, a Personal Support Worker (PSW) was unable to identify what the preferences of the resident would be for bathing as it was not clearly identified in the Kardex.

A review of the resident's care plan stated how to bath the resident. No indication of a preference for showers or baths was documented. The resident's RAI-Pre admission data sheet stated what the resident preferred.

During an interview, a Registered Practical Nurse (RPN) verified the resident's care plan

and was unable to find the resident's preferences for bathing. The RPN stated that it was the expectation that the residents' needs and preferences should be listed in the care plan.

The licensee has failed to ensure that the plan the care was based on the assessment of the two residents' needs and preferences [s. 33. (1)]

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 26. (3) 21.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine were supported and individualized to promote comfort, rest and sleep.

During a resident interview for Stage 1 of the Resident Quality Inspection a resident mentioned what desired bedtime and rest routine was preferred.

During an interview, the resident stated that staff were not supportive of the desired bedtime and rest routine and that no one asked about desired bedtime and rest routine. The resident stated that this preference was brought up to staff many times.

A review of the home's "Resident Rights - Dignity, Choices & Privacy Policy", stated: "Policy: All staff will provide care with respect, dignity and privacy by encouraging and assisting residents to make choices based on their preferences, needs and condition. These choices and preferences will be outlined in the resident's plan of care. The plan of care will ensure that all Resident's Rights are followed and respected." and "Key resident preferences and needs to be documented: Resident's customary routines of daily living, Cultural, spiritual and religious preferences, Desired bedtime and sleep patterns".

A review of the resident's care plan in Point Click Care (POC) showed no documented evidence of desired bedtime and rest routine.

During an interview, the RPN RAI Coordinator, RPN and PSW stated that the resident was not assessed for desired bedtime and rest routine. The RPN RAI Coordinator, RPN and PSW stated that the resident preferences were reported to staff and that the desired bedtime and rest routine were not in the resident's plan of care. The RAI Coordinator stated that the expectation is that a resident's desired bedtime and rest routine should be assessed and be part of the plan of care of residents and be respected and promoted by staff.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

During Stage 1 of the Resident Quality Inspection, 2016 height measurements were noted to be missing for five residents.

During interviews, two Registered Practical Nurses (RPN) stated that registered staff were responsible for measuring residents' heights on admission, and that heights were not measured at any other time.

During an interview, a Nurse Manager stated that the expectation was that residents' heights were done on admission and annually and reported that Personal Support Workers (PSW) measured heights and reported them to registered staff, who record the heights in Point Click Care (PCC). The Nurse Manager stated that a nurse manager or registered staff were responsible for ensuring that PSWs completed heights and weights for the year. The Nurse Manager stated that the home did not have a system in place for ensuring that annual heights were completed. The Nurse Manager reviewed heights in PCC for five identified residents and acknowledged that the most current heights for these residents were measured in 2015. The Nurse Manager stated that these heights were not completed, and that it was the home's expectation that heights were done annually.

The licensee has failed to ensure that there was a system to measure and record the annual heights for the five residents.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 68. (2) (e) (ii)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the satisfaction survey.

During an interview, the Residents' Council representative stated that they did not recall having opportunity to review the Satisfaction Survey prior to being provided with the survey to complete.

During an interview, the Life Enrichment Director, who attends and assists the Residents' Council at meetings, stated that they do not recall that the Satisfaction Survey had been provided for review to the Residents' Council prior to it being completed. The Life Enrichment Director stated that the results of the survey were shared with the Residents' Council as well as a copy of the document for review, and the results and comments from residents were discussed. This was documented in the meeting minutes. The Life Enrichment Director reviewed the meeting minutes and was unable to find documentation to support that the Residents' Council had been given opportunity to review the satisfaction survey prior to it being completed.

The Administrator was not employed at the time of the completion of the last satisfaction survey and stated that they had contacted the previous Administrator of the home. The Administrator stated that the previous Administrator had not sought the advice of the Residents' Council in developing and carrying out the satisfaction survey.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record for complaints is kept in the home.

During Stage 1 of the Resident Quality Inspection in an interview, a resident stated that items had been stolen and this was reported to staff.

A review of the home's Complaints and Concerns Policy, dated November 30, 2010, stated: "All complaints and concerns, whether verbal, email, written or voice mail are to be documented on the Client Service Response Form and Response and Resolution Form for performance quality improvement initiatives." and, "A verbal complaint, concern or any request for information about resident care or the operation of the home from a resident, his/her family, a visitor, volunteer or any member of the public, shall be responded to immediately by the individual it is addressed to unless circumstances necessitate a delay or if the issue has to be referred to a Departmental Manager. A response to a complaint should indicate what will be done to resolve the complaint or why, if in the opinion of the home's representative, there is no cause for complaint".

A review of the home's binder "Concerns Complaint" for 2016 and 2017 did not include documented evidence of verbal or written, complaints or concerns, for this resident.

During an interview, a Personal Support Worker (PSW) stated that it was mentioned that the resident had lost something and did not think it was ever found. The PSW stated that

the expectation was to report to the team leader of the floor.

During an interview, a Registered Practical Nurse (RPN) stated that the resident mentioned to staff that items were stolen a while ago, a couple of months. The RPN stated that they were unsure if it was reported or followed-up with and did not believe there was a policy on that.

During an interview, the Director of Nursing (DON) stated that the resident's complaint was not documented. The DON stated that an investigation was completed for the complaint but was unable to provide documentation to support it. The DON stated that the expectation is to follow the home's policy and document complaints or concerns as per their policy.

The licensee has failed to ensure that a documented record for complaints was kept in the home for the resident.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 101. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

During a medication observation, a Registered Practical Nurse (RPN) was observed opening the lower drawer of the medication cart where the controlled substances were stored. It was observed that the controlled substances box within the cart was not locked. The RPN stated that the expectation was that controlled substances should be double-locked in the medication cart.

During Interviews, the Administrator and RPN stated that it was the expectation that controlled substances in the medication cart be double locked at all times.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 129. (1) (b)]

Issued on this 20th day of April, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HELENE DESABRAIS (615), ALICIA MARLATT (590), ANDREA DIMENNA (669), NANCY SINCLAIR (537), TRACY RICHARDSON (680)
Inspection No. / No de l'inspection :	2017_418615_0002
Log No. / Registre no:	003099-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 12, 2017
Licensee / Titulaire de permis :	COPPER TERRACE LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	COPPER TERRACE 91 TECUMSEH ROAD, CHATHAM, ON, N7M-1B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tanya Shreve

To COPPER TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall ensure that all staff participate in the implementation of the infection prevention control program.

Specifically the licensee shall ensure:
a)Resident's care items are labelled and stored properly
b)Hand washing is performed in between residents' care
c)Disinfecting devices when used in between residents

Grounds / Motifs :

1. During the initial tour of the home of the Resident Quality Inspection, several residents' personal care items were observed to be unlabelled and/or stored improperly.

On six different days, in a sitting lounge on an identified unit, two Inspectors observed an aerosol mask with fingerprints and dried secretions on it and, an aerosol machine sitting on top of books on a table. The aerosol machine and mask were not labelled with a resident's name.

On a specific date, a Nurse Manager and an Inspector observed the unlabelled aerosol machine and mask. The Nurse Manager agreed that there was no name on the items and that these items should be kept either in the resident's room or discarded after each use. The Nurse Manager acknowledged that there was an infection control concern with this personal care item being left out.

On a specific date, in two resident rooms, shared bathroom on an identified unit, an Inspector observed two unlabelled urinals sitting beside the sink.

On two different days, in a resident's room, shared bathroom on an identified

unit, an Inspector observed two toothbrushes, a denture cup, toothpaste and a bottle of cream, unlabeled and all sitting on the shared sink vanity.

On a specific date, in a resident's room, shared bathroom on an identified unit, an Inspector observed two unlabelled toothbrushes, one sitting on the vanity and one on the paper towel rack. An Inspector and a Registered Practical Nurse (RPN) observed two unlabelled toothbrushes, one sitting on the vanity and one on the paper towel rack. The RPN shared that the expectation was that all residents' personal care items are to be labelled and stored properly.

On three different dates, in a tub room on an identified unit, two Inspectors observed two nail clippers unlabelled and sitting on the shared vanity.

On a specific date, in a tub room on an identified unit, an Inspector and an RPN observed an opened and used bar of soap, nail clippers with nail clippings sitting on top of the residents' personal items storage bin. The items were both unlabelled. The RPN shared that the expectation was that all resident's personal care items are to be labelled and stored properly.

During an interview the Director of Nursing (DON) stated that aerosol masks should be kept in the resident room or discarded after use and that it poses an infection control issue when not stored properly. The DON shared that the expectation was that all residents' personal care items are to be labelled with the resident's name and stored properly for infection prevention and control.

During a medication observation, on an identified resident home area, an Inspector observed an RPN administrating medications to different residents without washing hands in between. The RPN stated that one glucometer is used for all residents and is not disinfected in between residents. The RPN shared that hand washing and disinfecting the glucometer between residents would be an expectation.

Review of the home's "Infection Prevention & Control" Policy under Routine Practices, stated: "Hand hygiene is mandatory before and after all resident care. Examples of hand hygiene must be performed: Before any sterile procedure, Before preparing medications, Before starting work and before leaving the work area, Before direct resident care". "Waste. Contain biomedical waste, (e.g., sponges, dressings or surgical drapes soaked with blood or secretions) in impervious waste-holding bags or double bags".

During an interview, the Administrator and an RPN stated that it is the home's expectation to wash hands in between residents' care during the medication pass and to disinfect the glucometer when using it between residents.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 16, 2015, as a Compliance Order (CO) in a Resident Quality Inspection #2015_257518_0016. [s. 229. (4)] (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Helene Desabrais

Service Area Office /
Bureau régional de services : London Service Area Office