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
Jun 16, 2017	2017_262630_0013	009704-17	Complaint

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

AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 30, 31 and June 1, 2017.

The following Complaint inspection was conducted:
Log #009704-17/IL-50864-LO – Complaint related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), two Nurse Managers, the Resident Assessment Instrument (RAI) Co-ordinator, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the Pastor, one Registered Nurse (RN), five RPNs, six Personal Support Workers (PSWs), six residents and two family members.

The inspectors 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, reviewed meeting minutes, reviewed policies and procedures of the home and reviewed staff education records.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **2 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 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 the written policy to promote zero tolerance of

abuse and neglect of residents was complied with.

The home's policy titled "Abuse – Prevention, Elimination and Reporting Policy" which was in effect in the home since December 2015 included the following procedures:
- The registered staff member must "immediately contact the Administrator, Director of Nursing (DON) or delegate regarding any alleged, suspected or witnessed incident of resident abuse."
- The Administrator, Director of Nursing (DON) or delegate will "ensure that the resident's representative is informed of the incident immediately and of the status of the investigation."
- "For incidents that meet the criteria for reporting to the Police or MOHLTC time and date of notification will be documented in the resident's chart."
-"The Administrator/DON/delegate will ensure the MOHLTC is notified via telephone and shall complete a Critical Incident System (CIS) report via the ltchomes.net website as required."
- "The person receiving the initial report shall obtain a detailed account of the incident from the person reporting the incident and shall be in the person's own words and signed by the person."
- "The staff member receiving the initial report shall initiate the "Investigations of Allegations of Abuse" form."
- "The Administrator/DON or delegate will meet with all parties identified in the incident."
- "Information obtained during the investigation will be documented in writing."
- "Investigation will include consultation with the attending physician and a comprehensive review of appropriate documentation sources to determine the competency of resident's involved, past history, psychiatric or neurological causes and perceived risk."

a) During the inspection a Nurse Manager (NM) provided Inspector #630 with a copy of an "Investigation of Allegations of Abuse" form for a specific incident that occurred between two identified residents.

During an interview with an identified staff member it was reported that recently they found two identified residents touching one another. This staff member said they reported this event to the registered staff working at the time. This staff member said they were asked to write a statement about what they observed but otherwise had not been interviewed by any management in the home.

During an interview with another identified staff member it was reported that two

identified residents were found touching one another. This staff member said they spoke with one of the identified residents, called the family members right away about the incident and they had no concerns. This staff member said they reported this incident to a NM and was told not to call the police or to do an incident report because the family of the resident was not concerned.

During an interview with a NM they told Inspector #630 that they had been notified by staff that two residents had been found touching one another. This NM said that based on a discussion with staff they did not consider this to be alleged abuse. The NM said that apart from talking with the staff and the Director of Nursing (DON) about the incident they did not take further action. This NM said that they did not consider this activity to be alleged abuse.

During an interview with another NM they said they completed the "Investigation of Allegations of Abuse" form based on the investigation notes from another NM. Inspector #630 reviewed this report with this NM and they acknowledged that the family had been notified by staff and there had been no further contact with the family by any management after the investigation. The NM also acknowledged that the attending physician was not notified, that the police were not notified and that a CI Report was not submitted to the MOHLTC. This NM said they did not personally interview any staff or residents related to this incident.

During an interview with the DON they said that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management. The DON said that they did not consider the incident between these two identified residents to be abuse.

b) During an interview with an identified staff member they reported that there had been a specific incident between two identified residents. The staff member reported that because the resident did not seem to be harmed they did not report the incident to management or take further action apart from documenting a progress note and monitoring the residents.

The clinical record included a progress note which described the specific incident and the "action taken" in documented in this note stated "staff monitored both residents for duration of shift with no further incidents."

During an interview a NM told Inspector #630 that one of the identified residents had a

history of responsive behaviours. This NM said they had been notified of an incident that occurred between these two residents. This NM showed Inspector #630 the "Investigation of Allegations of Abuse" form that was completed and this identified that an incident had occurred between these two residents. NM said that they did not consider this to be alleged abuse and no further action was needed other than documenting in the progress notes and notifying the families.

During an interview the DON said that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management. The DON said that they did not consider the incident between these two residents to be alleged abuse. DON said they looked for the witness statements from this incident and was unable to locate them at the time of the inspection. The DON said that the home did not follow all parts of the home's policy on the prevention of abuse and neglect as based on the discussion staff it was not considered to be alleged abuse.

c) A progress note for another identified resident showed that there was an incident that occurred between this resident another resident in the home. This progress indicated that action taken was "staff separated both residents, residents were taken back to their room. Staff have monitored resident closely, no further incident noted."

During interviews with a NM and the DON they identified that they were not aware of that incident. This NM said they were not informed of this incident and did not investigate or have any involvement in follow-up regarding this incident. This NM said that another member of the management team may have been involved but they had not been made aware of any investigation. The DON reviewed their records said that there was no internal incident report or CI System Report submitted to the MOHLTC regarding this incident. The DON said that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management including front line staff notifying the NM or DON of any incidents of potential resident to resident abuse.

Based on these interviews and record reviews the licensee has failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with in regards to multiple areas of the policy. The policy was not complied as it related to staff immediately reporting incidents of alleged abuse to management, informing the resident's representative of the status of the investigation, notification of Police and the MOHLTC, documentation of investigations and comprehensive review of the competency of resident's involved, past history and perceived risk.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was determined to be widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 20, 2016, as a Voluntary Plan of Correction (VPC) in Resident Quality Inspection (RQI) #2016_262523_0018 and on February 21, 2017, as a VPC in RQI #2017_418615_0002. [s. 20. (1)]

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

a) The home submitted Critical Incident (CI) System Report to the Ministry of Health and Long Term Care (MOHLTC) related to alleged resident to resident abuse.

During interviews with multiple staff during the inspection it was reported that prior to the incident one of the identified residents had a history of responsive behaviours that were of a similar nature to what had reportedly occurred during the incident.

During an interview with an identified staff member it was reported that the internal BSO team had been following the identified resident at the time of the incident. This staff looked at their documentation in the clinical record and said that they had requested the physician check the resident for a specific type of test that could have been a contributing factor to behaviours but other than that did not complete further assessments to determine triggers for the behaviours, strategies to respond to these behaviours or the resident's responses to any interventions that were implemented. This staff member said that the plan of care was not updated to include interventions for the specific responsive behaviours.

During an interview with another identified staff member they looked in the electronic plan of care for this resident and said that the specific responsive behaviours were not currently included as responsive behaviours and had not been included in the past. This staff member said they were the ones responsible for updating care plans and that they had not received a request to update this plan of care for these responsive behaviours.

The clinical record for this identified resident showed this resident had a history of these specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural assessments, and that the plan of care did not include these responsive behaviours.

During an interview the DON told Inspector #630 that they did not think that this identified resident had this type of specific responsive behaviours. Inspector #630 reviewed the clinical record for this resident with the DON and they acknowledged that nothing was added to the plan of care based on an assessment of these specific behaviours.

During an interview with a NM they said that this identified resident was seen by the internal BSO team prior to the incident but did not have a documented assessment completed beyond the assessments documented as progress notes. This NM acknowledged that this resident had a history of these specific responsive behaviours. This NM said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as needed and then included in the plan of care.

Based on these interviews and clinical record reviews this identified resident was demonstrating specific responsive behaviours before and after the CI that had been reported to the MOHLTC. These interviews and clinical records also showed that the licensee failed to ensure the behavioural triggers were identified, strategies were developed and implemented to respond to these behaviours, and that assessments, reassessments and the responses to interventions were documented.

b) During interviews with multiple staff during the inspection it was reported that there had been an incident between two identified residents which involved a specific type of responsive behaviours. It was also reported that one of the identified residents had a history of that specific type of responsive behaviours.

During an interview with one of the identified staff member it was reported that they thought that one of the identified residents had a history of this type of responsive behaviours but those had settled down. This staff member said they were not aware of any recent incidents between these two identified residents.

During an interview with another identified staff member it was reported that this identified resident used to be followed by the internal BSO team however had been discharged from their program as their behaviours were thought to have improved. This staff member said there were no referrals received for this resident or recent assessments completed.

The clinical record for this identified resident showed this resident had a history of these specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural re-assessments, and that the plan of care did not include the recent responsive behaviours.

During an interview with a NM they told Inspector #630 that this identified resident did have a history of these specific responsive behaviours and they had been notified of an incident that occurred between these two residents. NM said that because they did not consider this to be alleged abuse no further action was needed other than documenting the incident and notifying the families.

During an interview with another identified staff member they said that this identified resident was seen the by internal BSO team in the past, did not have any documented assessments completed recently or updates to the plan of care. This NM acknowledged that this resident had a history of this specific type of responsive behaviours. This NM

said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as needed and then included in the plan of care.

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The home completed an "Investigation of Allegations of Abuse" form regarding an incident that occurred between two identified residents which was related to a specific type of responsive behaviours.

During interviews with multiple staff during the inspection it was reported that there had been an incident between two identified residents which involved a specific type of responsive behaviours. It was also reported that there was no history of this type of behaviours or incidents for one of the identified residents.

During an interview with a NM they told Inspector #630 that they had been notified that two identified residents had been found touching one another. This NM said that because they did not consider this to be alleged abuse and apart from talking with staff and the DON about the incident they did not take further action.

The clinical record for this identified resident showed this resident had no history of this specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural assessments for this specific behaviour, and that the plan of care did not include the recent responsive behaviours.

During an interview with another NM they said they completed the "Investigation of Allegations of Abuse" form based on the investigation notes from another NM. Inspector #630 reviewed this report with this NM and they acknowledged that apart from the education provided to the identified resident at the time of the incident there was no other referrals made for this resident. This NM said that this resident was not assessed by the BSO team after the incident and the plan of care was not updated. This NM said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as needed and then included in the plan of care.

Based on these interviews and clinical record reviews the licensee has failed to ensure the residents demonstrating responsive behaviours of a specific nature had behavioural

triggers identified, strategies developed and implemented, as well as assessments and reassessments documented.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was determined to be widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

1) During an interview with an identified staff member they told Inspector #630 that there had been an incident between two identified residents. This staff member reported that because the resident did not seem to be harmed they did not report the incident to management or take further action apart from documenting a progress note and monitoring the residents.

The clinical record included a progress note which described the incident that had occurred between these two identified residents. The "action taken" in documented in this note stated "staff monitored both residents for duration of shift with no further incidents."

During an interview with another identified staff member they reported that the incident

had occurred between these two residents related to a specific type of responsive behaviours and one of the residents had a long standing history of this type of behaviours.

During an interview with a NM they told Inspector #630 that this identified resident had a history of this type of specific responsive behaviours. This NM said they had been notified of an incident that occurred between these two residents. This NM showed Inspector #630 the "Investigation of Allegations of Abuse" form that was completed and this described the incident. This NM said that because the resident was not in distress and because NM did not consider this to be abuse no further action was needed other than documenting in the progress notes and notifying the families. This NM said they did not have copies of the witness statements to provide to the inspector but thought they had been completed.

During an interview with the DON they reported that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management. The DON said that they did not consider the incident between these two identified residents to be abuse as the resident would express when they disliked something and the family was not concerned. The DON said they looked for the witness statements and were unable to locate them at the time of the inspection. The DON said that the home did not follow all parts of the home's policy on the prevention of abuse and neglect as based on the discussion the NM had with the staff it was not considered to be alleged abuse.

Based on these interviews and clinical record reviews this identified resident was demonstrating a specific type of responsive behaviours before the incident occurred. These interviews and clinical records also showed that the management in the home did not fully investigate this incident and when it was reported and they determined, based on initial conversations with staff, that they did not consider this to be alleged abuse.

2) The home submitted a Critical Incident (CI) System Report to the Ministry of Health and Long Term Care (MOHLTC) on which was identified as "unlawful conduct that resulted in harm/risk of harm to resident". This report described an incident that occurred between two identified residents.

During interviews with family members for an identified resident they expressed concerns regarding the incident and the home's investigation of this incident.

During interviews with identified staff members during the inspection it was reported that there had been an incident between two identified residents which involved responsive behaviours of specific nature. Staff reported that this resident had a history of this type of specific responsive behaviours prior to and after the incident reported to the MOHLTC.

During an interview with an identified staff member they reported that the Behavioural Supports Ontario (BSO) team had been following this identified resident at the time of the incident. They looked at their documentation in the clinical record and said that they had requested the physician to complete a specific type of test for this resident to assess for a potential contributing factor to the behaviours but otherwise did not complete further assessments to determine triggers for the behaviours, strategies to respond to these behaviours or the resident's responses to any interventions that were implemented. This staff member said that the plan of care was not updated to include interventions for the specific responsive behaviours.

The clinical record for this identified resident showed this resident had a history of these specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural assessments, and that the plan of care did not include these responsive behaviours.

During an interview with a Nurse Manager they said they had been involved in investigating the incident that occurred between these two identified residents. This NM said that based on discussion with the staff member who received the report of the incident they did not think that there was intent and for that reason they did not consider this to be abuse. This NM said that the staff did not feel that the resident was harmed and for that reason the management was not notified immediately of the incident. This NM said that they spoke with the staff who witnessed the incident but did not have them write statements and after they followed up with staff the description of the event changed. This NM said that from what they knew from their investigation the details of the incident the staff member had reported changed after the initial report. This NM reviewed the clinical record for this identified resident with Inspector #630. This NM said that resident was seen by the BSO team prior to the incident but did not have a documented assessment completed beyond the assessments documented as progress notes in the electronic documentation system. This NM acknowledged that this resident had a history of specific responsive behaviours and these were not included in the plan of care at any time. This NM said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as needed and then included in the plan of care and this was not done for this resident prior to the incident.

During an interview the DON told Inspector #630 that they did not think that this identified resident had this specific type of responsive behaviours. The DON said that they had not been notified of a previous incident which involved similar responsive behaviours between this identified resident and another that had occurred prior to the reported incident. Inspector #630 reviewed the clinical record for this identified resident with the DON and they acknowledged that nothing was added to the plan of care based on an assessment for these specific responsive behaviours. The DON said they thought that the CI was related to a resident who accidentally went into another room and it was not alleged abuse and this was based that on the information provided by the Nurse Managers who investigated the incident.

Based on these interviews and clinical record reviews this identified resident was demonstrating specific responsive behaviours before the incident. The interviews and clinical records showed that this resident was found by staff touching another identified resident. These interviews and clinical records also showed that the management in the home did not fully investigate this incident and when it was reported and they determined, based on initial conversations with staff, that they did not consider this to be alleged abuse.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 19. (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 by ensuring all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that person who had reasonable grounds to suspect that any of the following has occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

a) During an interview with an identified staff member it was reported that there was an incident between two identified residents.

The "Investigations of Allegations of Abuse" form indicated that notification of the Ministry of Health and Long Term Care (MOHLTC) was "not applicable".

During an interview with a NM they said it was part of their role was to notify the Director through the CI System of any alleged incidents of abuse in the home. This NM said they had been notified of an incident that occurred between two identified residents. This NM said that because the resident was not in distress and because NM did not consider this to be abuse, no further action was needed including notifying the Director.

b) The home completed an "Investigation of Allegations of Abuse" form regarding an incident that occurred between two other identified residents. This form indicated that notification of the Director was not applicable.

During an interview a NM told Inspector #630 that part of their role was to notify the Director through the CI System of any alleged incidents of abuse in the home. This NM said they had been notified of an incident between two identified residents. This NM said that because the resident was not in distress they did not consider this to be abuse the Director was not notified through the CI System.

c) During an interview Inspector #630 asked the DON how the home determined when the Director would be notified of an incident related to potential abuse they said that it would be if a resident or a family were in distress about an incident or if the resident was not able to defend themselves or there was no way for the resident to express that they did not want the touch. The DON said it was the expectation in the home that they would notify the Director if they suspected abuse but in these incidents they thought there was no risk to the resident and they did not meet the definition of alleged abuse based on the Nurse Manager's discussion with the front line staff.

The severity was determined to be a level two as there was 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 November 26, 2014, as a Written Notification in Critical Incident (CI) Inspection #2014_256517_0054. [s. 24. (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 by ensuring a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: 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. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

a) During an interview with an identified staff member it was reported that there was an incident between two identified residents. They said that in a previous incident police were notified but not in this instance.

The "Investigations of Allegations of Abuse" form indicated that notification of the police was "not applicable".

During an interview with a NM they had been notified of an incident that occurred between two identified residents. This NM said that because the resident was not in distress and because NM did not consider this to be abuse, no further action was needed including notifying the police.

b) The home completed an "Investigation of Allegations of Abuse" form regarding an incident that occurred between two identified residents. This form indicated that notification of the police was not applicable.

During an interview with an identified staff member they reported there had been an incident between two identified residents. This staff member said they reported this incident to NM and was told not to call the police because the family of the resident was not concerned.

c) The home submitted Critical Incident (CI) System Report to the Ministry of Health and Long Term Care (MOHLTC) which was identified as "unlawful conduct that resulted in harm/risk of harm to resident". This report stated that the police were notified about this

incident.

During an interview with family members for an identified they told Inspector #630 that the police were not notified until they spoke with the management in the home and insisted that the home call the police and that did not occur until several hours after the incident.

The clinical record showed that the police were called at the request of the family regarding this specific incident.

During an interview a NM they said that the family requested the police be called and another member of the management team called the police.

d) During an interview Inspector #630 asked the DON how the home determined when police would be called for an incident and they said that it would be if a resident or a family were in distress about an incident or if the resident was not able to defend themselves or there was no way for the resident to express that they did not want the touch. The DON said it was the expectation in the home that they would immediately call the police if they thought that based on their investigation the incident involved a criminal offence.

The severity was determined to be a level one as there was minimal risk of harm. The scope of this issue was determined to be a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [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 by ensuring 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.

Issued on this 19th day of June, 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) :	AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2017_262630_0013
Log No. / Registre no:	009704-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 16, 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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect is complied with.

The licensee shall ensure that all staff are re-trained on the home's policy including reporting mechanisms, notification of police, immediate reporting to the Director, documentation of internal investigations into alleged abuse and what is to be included as part of the home's investigation.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Abuse – Prevention, Elimination and Reporting Policy" which was in effect in the home since December 2015 included the following procedures:
- The registered staff member must "immediately contact the Administrator, Director of Nursing (DON) or delegate regarding any alleged, suspected or witnessed incident of resident abuse."
- The Administrator, Director of Nursing (DON) or delegate will "ensure that the resident's representative is informed of the incident immediately and of the status of the investigation."
- "For incidents that meet the criteria for reporting to the Police or MOHLTC time and date of notification will be documented in the resident's chart."
-"The Administrator/DON/delegate will ensure the MOHLTC is notified via telephone and shall complete a Critical Incident System (CIS) report via the

ltchomes.net website as required."
- “The person receiving the initial report shall obtain a detailed account of the incident from the person reporting the incident and shall be in the person’s own words and signed by the person.”
- "The staff member receiving the initial report shall initiate the “Investigations of Allegations of Abuse” form."
- “The Administrator/DON or delegate will meet with all parties identified in the incident.”
- “Information obtained during the investigation will be documented in writing.”
- “Investigation will include consultation with the attending physician and a comprehensive review of appropriate documentation sources to determine the competency of resident’s involved, past history, psychiatric or neurological causes and perceived risk.”

a) During the inspection a Nurse Manager (NM) provided Inspector #630 with a copy of an “Investigation of Allegations of Abuse” form for a specific incident that occurred between two identified residents.

During an interview with an identified staff member it was reported that recently they found two identified residents touching one another. This staff member said they reported this event to the registered staff working at the time. This staff member said they were asked to write a statement about what they observed but otherwise had not been interviewed by any management in the home.

During an interview with another identified staff member it was reported that two identified residents were found touching one another. This staff member said they spoke with one of the identified residents, called the family members right away about the incident and they had no concerns. This staff member said they reported this incident to a NM and was told not to call the police or to do an incident report because the family of the resident was not concerned.

During an interview with a NM they told Inspector #630 that they had been notified by staff that two residents had been found touching one another. This NM said that based on a discussion with staff they did not consider this to be alleged abuse. The NM said that apart from talking with the staff and the Director of Nursing (DON) about the incident they did not take further action. This NM said that they did not consider this activity to be alleged abuse.

During an interview with another NM they said they completed the "Investigation of Allegations of Abuse" form based on the investigation notes from another NM. Inspector #630 reviewed this report with this NM and they acknowledged that the family had been notified by staff and there had been no further contact with the family by any management after the investigation. The NM also acknowledged that the attending physician was not notified, that the police were not notified and that a CI Report was not submitted to the MOHLTC. This NM said they did not personally interview any staff or residents related to this incident.

During an interview with the DON they said that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management. The DON said that they did not consider the incident between these two identified residents to be abuse.

b) During an interview with an identified staff member they reported that there had been a specific incident between two identified residents. The staff member reported that because the resident did not seem to be harmed they did not report the incident to management or take further action apart from documenting a progress note and monitoring the residents.

The clinical record included a progress note which described the specific incident and the "action taken" in documented in this note stated "staff monitored both residents for duration of shift with no further incidents."

During an interview a NM told Inspector #630 that one of the identified residents had a history of responsive behaviours. This NM said they had been notified of an incident that occurred between these two residents. This NM showed Inspector #630 the "Investigation of Allegations of Abuse" form that was completed and this identified that an incident had occurred between these two residents. NM said that they did not consider this to be alleged abuse and no further action was needed other than documenting in the progress notes and notifying the families.

During an interview the DON said that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management. The DON said that they did not consider the incident between these two residents to be alleged abuse. DON said they looked for the witness statements from this incident and was unable to locate them at

the time of the inspection. The DON said that the home did not follow all parts of the home's policy on the prevention of abuse and neglect as based on the discussion staff it was not considered to be alleged abuse.

c) A progress note for another identified resident showed that there was an incident that occurred between this resident another resident in the home. This progress indicated that action taken was "staff separated both residents, residents were taken back to their room. Staff have monitored resident closely, no further incident noted."

During interviews with a NM and the DON they identified that they were not aware of that incident. This NM said they were not informed of this incident and did not investigate or have any involvement in follow-up regarding this incident. This NM said that another member of the management team may have been involved but they had not been made aware of any investigation. The DON reviewed their records said that there was no internal incident report or CI System Report submitted to the MOHLTC regarding this incident. The DON said that it was the expectation in the home that the written policy regarding the prevention of abuse and neglect was complied with by all staff and management including front line staff notifying the NM or DON of any incidents of potential resident to resident abuse.

Based on these interviews and record reviews the licensee has failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with in regards to multiple areas of the policy. The policy was not complied as it related to staff immediately reporting incidents of alleged abuse to management, informing the resident's representative of the status of the investigation, notification of Police and the MOHLTC, documentation of investigations and comprehensive review of the competency of resident's involved, past history and perceived risk.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was determined to be widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 20, 2016, as a Voluntary Plan of Correction (VPC) in Resident Quality Inspection (RQI) #2016_262523_0018 and on February 21, 2017, as a VPC in RQI #2017_418615_0002. [s. 20. (1)] (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure for four identified residents and for each resident demonstrating responsive behaviours, actions are taken to respond to those needs of the resident including assessments, reassessments and implementation of interventions and that the resident's responses to the interventions are documented.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

a) The home submitted Critical Incident (CI) System Report to the Ministry of Health and Long Term Care (MOHLTC) related to alleged resident to resident abuse.
During interviews with multiple staff during the inspection it was reported that prior to the incident one of the identified residents had a history of responsive behaviours that were of a similar nature to what had reportedly occurred during the incident.

During an interview with an identified staff member it was reported that the internal BSO team had been following the identified resident at the time of the incident. This staff looked at their documentation in the clinical record and said that they had requested the physician check the resident for a specific type of test that could have been a contributing factor to behaviours but other than that did not complete further assessments to determine triggers for the behaviours, strategies to respond to these behaviours or the resident's responses to any interventions that were implemented. This staff member said that the plan of care was not updated to include interventions for the specific responsive behaviours.

During an interview with another identified staff member they looked in the electronic plan of care for this resident and said that the specific responsive behaviours were not currently included as responsive behaviours and had not been included in the past. This staff member said they were the ones responsible for updating care plans and that they had not received a request to update this plan of care for these responsive behaviours.

The clinical record for this identified resident showed this resident had a history of these specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural assessments, and that the plan of care did not include these responsive behaviours.

During an interview the DON told Inspector #630 that they did not think that this identified resident had this type of specific responsive behaviours. Inspector #630 reviewed the clinical record for this resident with the DON and they acknowledged that nothing was added to the plan of care based on an assessment of these specific behaviours.

During an interview with a NM they said that this identified resident was seen by the internal BSO team prior to the incident but did not have a documented assessment completed beyond the assessments documented as progress notes. This NM acknowledged that this resident had a history of these specific responsive behaviours. This NM said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as needed and then included in the plan of care.

Based on these interviews and clinical record reviews this identified resident was demonstrating specific responsive behaviours before and after the CI that had been reported to the MOHLTC. These interviews and clinical records also showed that the licensee failed to ensure the behavioural triggers were identified, strategies were developed and implemented to respond to these behaviours, and that assessments, reassessments and the responses to interventions were documented.

b) During interviews with multiple staff during the inspection it was reported that there had been an incident between two identified residents which involved a specific type of responsive behaviours. It was also reported that one of the identified residents had a history of that specific type of responsive behaviours.

During an interview with one of the identified staff member it was reported that they thought that one of the identified residents had a history of this type of responsive behaviours but those had settled down. This staff member said they were not aware of any recent incidents between these two identified residents.

During an interview with another identified staff member it was reported that this identified resident used to be followed by the internal BSO team however had been discharged from their program as their behaviours were thought to have improved. This staff member said there were no referrals received for this resident or recent assessments completed.

The clinical record for this identified resident showed this resident had a history of these specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural re-assessments, and that the plan of care did not include the recent responsive behaviours.

During an interview with a NM they told Inspector #630 that this identified resident did have a history of these specific responsive behaviours and they had been notified of an incident that occurred between these two residents. NM said that because they did not consider this to be alleged abuse no further action was needed other than documenting the incident and notifying the families.

During an interview with another identified staff member they said that this identified resident was seen the by internal BSO team in the past, did not have any documented assessments completed recently or updates to the plan of

care. This NM acknowledged that this resident had a history of this specific type of responsive behaviours. This NM said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as needed and then included in the plan of care.

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The home completed an "Investigation of Allegations of Abuse" form regarding an incident that occurred between two identified residents which was related to a specific type of responsive behaviours.

During interviews with multiple staff during the inspection it was reported that there had been an incident between two identified residents which involved a specific type of responsive behaviours. It was also reported that there was no history of this type of behaviours or incidents for one of the identified residents.

During an interview with a NM they told Inspector #630 that they had been notified that two identified residents had been found touching one another. This NM said that because they did not consider this to be alleged abuse and apart from talking with staff and the DON about the incident they did not take further action.

The clinical record for this identified resident showed this resident had no history of this specific responsive behaviours prior to the incident, that the Assessment section of the electronic documentation system included no behavioural assessments for this specific behaviour, and that the plan of care did not include the recent responsive behaviours.

During an interview with another NM they said they completed the "Investigation of Allegations of Abuse" form based on the investigation notes from another NM. Inspector #630 reviewed this report with this NM and they acknowledged that apart from the education provided to the identified resident at the time of the incident there was no other referrals made for this resident. This NM said that this resident was not assessed by the BSO team after the incident and the plan of care was not updated. This NM said that it was the expectation in the home that these types of responsive behaviours were assessed and reassessed as

needed and then included in the plan of care.

Based on these interviews and clinical record reviews the licensee has failed to ensure the residents demonstrating responsive behaviours of a specific nature had behavioural triggers identified, strategies developed and implemented, as well as assessments and reassessments documented.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was determined to be widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 53. (4) (c)] (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 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 16th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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