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 # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2018	2018_563670_0005	002413-18	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

DEBRA CHURCHER (670), ALICIA MARLATT (590), ANDREA DIMENNA (669), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 19, 20, 21, 22, 23, 26, 27, 28, 29, April 3, 4, 5, 6, 9 and 10, 2018.

Inspector Cassandra Taylor #725 was present for this inspection.

The following complaints were inspected during this Resident Quality Inspection (RQI):
Log# 025215-17 Infoline #53846-LO related to availability of supplies and infection

control.
Log# 009861-17 Infoline #50871-LO related to alleged abuse and neglect, food production and continence care.
Log# 005454-18 Infoline #56082-LO related to 24/7 Registered Nurse staffing.

The following follow up to Orders of the inspector was completed during this RQI:
Log# 012151-17 Follow up to order #001 and order #002 from Complaint Inspection #2017_262630_0013 related to responsive behaviors and the home's abuse policy.
Log# 008055-17 Follow up to order #001 from Resident Quality Inspection #2017_418615_0002 related to infection control.

The following Critical Incident System (CIS) reports were inspected during this RQI:
Log# 004911-17 CIS #1115-000015-17 related to a fall with injury.
Log# 018119-17 CIS #1115-000037-17 related to a fall with injury.
Log# 021777-17 CIS #1115-000042-17 related to a fall with injury.
Log# 022599-17 CIS #1115-000043-17 related to a fall with injury.
Log# 003051-18 CIS #1115-000003-18 related to a fall with injury.
Log# 004423-17 CIS #1115-000012-17 related to a missing controlled substance.
Log# 001335-18 CIS #1115-000002-18 related to a missing controlled substance.
Log# 012656-17 CIS #1115-000026-17 related to a missing controlled substance.
Log# 016520-17 CIS #1115-000034-17 related to resident to resident abuse and responsive behaviors.
Log# 018437-17 CIS #1115-000038-17 related to resident to resident abuse and responsive behaviors.
Log# 015553-17 CIS #1115-000032-17 related to resident to resident abuse and responsive behaviors.
Log# 017559-17 CIS #1115-000035-17 related to resident to resident abuse and responsive behaviors.
Log# 011891-17 CIS #1115-000025-17 related to resident to resident abuse and responsive behaviors.
Log# 027636-17 CIS #1115-000050-17 related to resident to resident abuse and responsive behaviors.
Log# 004164-17 CIS #1115-000014-17 related to resident to resident abuse and responsive behaviors.
Log# 015894-17 CIS #1115-000029-17 related to resident to resident abuse and responsive behaviors.
Log# 005428-18 CIS #115-000009-18 related to resident to resident abuse and responsive behaviors.

During the course of the inspection, the inspector(s) spoke with more than forty residents, Residents' Council representative, the Family Forum representative, the Executive Director, the Acting Director of Care, the Director of Environmental Services, the Director of Culinary Services, the Registered Dietitian, the Clinical Services Coordinator, the Clinical Services Manager, two Registered Practical Nurses, Resident Assessment Instrument Coordinators, one Registered Practical Nurse Behavior Supports Ontario, one Personal Support Worker Behavior Supports Ontario, two Registered Nurses, seven Registered Practical Nurses, one Laundry Aide, two Cooks, 13 Personal Support Workers, five Dietary Aides and more than three family members.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, dining, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records and the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
7 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2017_418615_0002	590
O.Reg 79/10 s. 53. (4)	CO #002	2017_262630_0013	670

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. 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 residents were protected from abuse by anyone.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, describing a specific incident.

Review of a specific resident's progress notes showed that the resident was found in a specific position and another specific resident was in the vicinity.

Review of a specific residents progress notes showed documentation that the specific resident had made a specific statement.

Review of the home's risk management report completed for this incident, progress notes, and assessments, showed that a specific resident had sustained specific injuries as a result of the incident.

The CIS report documented that an investigation took place and they determined that a specific event had occurred.

In an interview with Executive Director (ED), they acknowledged that the specific event had occurred. [s. 19. (1)]

2. The home placed a call to the info line at a specific time on a specific date, and submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date at a specific time.

Review of a specific resident's clinical record and the home’s submitted CIS report showed that a specific event had occurred on a specific date which resulted in specific injuries.

During an interview on a specific date with a specific resident the specific resident was able to recall the specific incident.

On a specific date at a specific time during an interview with the Executive Director they stated that they would consider this incident abuse. [s. 19. (1)]

3. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, describing a specific incident.

Review of a specific resident's progress notes showed that on a specific date the resident was found to have a specific injury.

The progress notes also showed that on a specific date a specific resident was found in a specific position with another specific resident in the area.

The CIS reports documented that investigations took place and they determined that the specific incident had occurred.

In an interview with Executive Director (ED), they acknowledged that the specific incident had occurred resulting in injury to a specific resident.

The licensee has failed to ensure that residents were protected from abuse by anyone. [s. 19. (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 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 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.

The home's Abuse – Prevention, Elimination & Reporting Policy, last revised in May 2017, states that "All staff members are required to report witnessed or suspected abuse." Further explanation is provided in the Protocol for Reporting Allegations of Resident Abuse procedure section, which states that 1) Immediately report alleged,

suspected or witnessed incidents to the registered staff member and 2) The registered staff member must immediately contact the Administrator, Director of Nursing or delegate.

A) Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, describing a specific concern from a specific resident regarding a specific incident.

Review of the specific resident's progress notes showed that the resident had reported incidents to staff on two occasions. One report was three days prior to the CIS being submitted and one was one day prior to the CIS being submitted.

In an interview with a specific PSW, they shared that when they see or hear of incidents of abuse, they would immediately report it to their team lead or manager.

In an interview with two specific Registered Practical Nurses, they said when they receive reports of abuse, resident safety needs to be ensured first, and then appropriate people are notified. They further shared that the MOHLTC, police, Executive Director (ED), Director of Care, physician and the substitute decision maker, if any, would all need to be notified as soon as possible.

In an interview with the ED, they stated that the incident should have been reported on a specific date to the ED, police, MOHLTC and any Substitute Decision Makers and was not.

B) The home's policy titled Abuse-Prevention, Elimination and Reporting Policy, last revised May 2017, stated, "All staff members are required to report witnessed or suspected abuse. The Administrator/Director of Nursing/Delegate will ensure the Ministry of Health and Long-Term Care is notified via telephone and shall complete a Critical Incident System report via the ltchomes.net website as required".

During an inspection of a Critical Incident System report (CIS), Inspector #670 observed documentation regarding an internal investigation into two specific incidents involving two specific residents. The original CIS being inspected had not involved the two specific residents.

Review of the two specific resident's clinical records showed that on two specific dates

there were incident's involving two specific residents.

Inspector #670 was unable to locate a CIS for either incident. The home completed a search for a CIS and was unable to provide Inspector #670 with a CIS report for either incident.

On a specific date at a specific time the ED stated that the home did not submit a CIS report and should have.

C) The home's policy titled Abuse-Prevention, Elimination and Reporting Policy, last revised May 2017, stated, "All staff members are required to report witnessed or suspected abuse. The Administrator/Director of Nursing/Delegate will ensure the Ministry of Health and Long-Term Care is notified via telephone and shall complete a Critical Incident System report via the ltchomes.net website as required."

On April 5, 2018, while Inspectors #670 and #725 were reviewing the investigation notes for a separate Critical Incident System report (CIS), documentation was observed in the file related to an incident that occurred on a specific date, related to a specific incident. This was immediately stopped and reported by staff. Police were called. MOHLTC infoline was called, POA's and physician were called. Inspectors #670 and #725 observed an email from the Executive Director (ED) to the acting Director of Care (DOC) dated for a specific date, requesting specific information to update the CIS. There was an email observed from the acting DOC on a specific date, stating that the Ministry of Health (MOH) had called regarding the original call to the info line asking for the CIS and listed a phone number. There was an email observed from the ED to the acting DOC dated for, requesting that next time the Ministry of Health and Long-Term Care called that the acting DOC call or page the ED and also stated they were currently updating the CIS's and asked if the acting DOC was able to provide any information to the Ministry of Health and Long-Term Care when they called.

Review of a specific resident's progress notes showed that a specific incident had occurred on a specific date.

On a specific date at a specific time, the ED stated that the home did not submit a CIS report and should have.

The licensee has failed to ensure that 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. [s. 20. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Inspector #670 observed a specific resident with a specific intervention in place. on two occasions.

Review of the specific resident's clinical record and care plan did not reveal any documentation or instruction for staff related to the use of the specific intervention.

On a specific date at a specific time a Personal Support Worker (PSW) stated that they used the interventions for the resident for comfort if the resident was doing a specific action.

On a specific date at a specific time a PSW stated that they did not have any instruction to perform a specific intervention for the specific resident but that the staff would perform the intervention if they were doing it for a specific reason.

On a specific date at a specific time the Clinical Services Manager reviewed the specific resident's electronic chart and care plan and acknowledged that there was no plan of care related to the use of the specific intervention.

2. Review of a specific resident's clinical record and did not reveal any instruction for staff related to the residents specific related care needs.

On a specific date at a specific time a Registered Practical Nurse (RPN) stated that the specific resident had specific care needs and if they were not familiar with the resident they would look in the care plan.

On a specific date at a specific time a PSW stated that the specific resident had specific care needs and if they did not know the resident they would look in the Point of Care (POC) documentation for instruction.

On a specific date at a specific time a review of the specific resident's clinical record was completed with CSM and Inspector #670. The CSM stated that they would expect to see specific instruction for staff related to the specific resident's care requirements in the care plan, kardex and Point of Care Tasks. The CSM acknowledged that there was no documented instruction for staff and stated that there should have been. [s. 6. (1) (c)]

3. During stage one of the Resident Quality Inspection (RQI) a specific resident was observed to have a specific intervention in place.

Review of the specific resident's care plan showed that the specific intervention was not included.

In an interview with a Registered Practical Nurse (RPN) they shared that any resident using the specific intervention should have directions in the care plan as to when and how the intervention should be applied.

In an interview with a RPN they said that previously, depending on the intervention, it may not necessarily have been included in the plan of care. They stated that new management had come into the home and had directed staff that moving forward, all specific interventions, will be included in the care plans.

The home's policy titled "Corporate Care Plan Policy" stated; The Care Plan is expected to include all aspects of care needed for the resident.

In an interview with Acting Director Of Care (ADOC) #127, they shared that if the tilt function on a wheelchair was used, it should be included in the resident's care plan to provide directions to staff when and how to use the device.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the residents. [s. 6. (1) (c)]

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 ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The Ministry of Health and Long-Term Care received an anonymous complaint through the infoline #56082-LO on March 17, 2018, regarding the home not having a Registered Nurse (RN) in the building 24/7.

Review of the RN staffing schedules for February and March 2018, showed that there was no RN in the long term care home on the following occasions:
February 25, 2018 – The afternoon shift had no RN for 4 hours, a RPN covered for the RN
February 26, 2018 – The day shift had no RN for 7.5 hours
February 27, 2018 – The day shift had no RN for 7.5 hours, a RPN covered for the RN
March 5, 2018 – The afternoon shift had no RN, a RPN covered for the RN
March 6, 2018 – The day shift had no RN, a RPN covered for the RN
March 9, 2018 – There was no RN for 4 hours on days
March 13, 2018 – There was no RN on days, a RPN covered for the RN
March 15, 2018 – There was no RN for days, a RPN covered for the RN
March 16, 2018 – There was no RN for days, a RPN covered for the RN
March 17, 2018 – There was no RN for days, a RPN covered for the RN
March 18, 2018 – There was no RN for days, a RPN covered for the RN
March 22, 2018 – There was no RN for days, a RPN covered for the RN
March 26, 2018 – There was no RN for days, a RPN covered for the RN
March 27, 2018 – There was no RN on days, a RPN covered for the RN
March 31, 2018 – There was no RN for days, a RPN covered for the RN and no RN for four hours on afternoons, a RPN covered for the RN.

In an interview with Clinical Services Coordinator (CSC), they shared that they are responsible for the scheduling of PSW's and registered staff members. They shared that there have been several recent occasions where there was no registered nurse in the building. The CSC was aware that a RN needed to be in the building at all times, whom was not a management team member. They shared that they have been offering overtime for approximately six to eight months now, however cannot make staff come in. They shared that the home recently hired three RN's so hopefully the RN staffing would improve in the near future.

The home's Executive Director acknowledged that there have been times where there had been no RN in the building, however said that a manager is always a phone call away any time they are needed by staff at the home.

The licensee has failed to ensure that there at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #5: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. 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 with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. The report documented that an incident occurred involving resident #008 that caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A specific resident was admitted to the home on a specific date, and was assessed as a moderate fall risk. Review of the specific resident's progress notes showed that the resident fell on a specific date, and was immediately transferred to hospital for further assessment as they sustained some injuries.

The admission care plan for the specific resident stated that the resident had specific abilities and specific care needs. Review of the specific resident's care plan after the fall,

showed that the care plan had not been updated after the resident returned to the home from the hospital to reflect the change in this resident's condition.

The progress notes for specific dates, were reviewed and showed that the resident had experienced a change in their condition.

The home's policy "Fall Risk Care Plan Policy", policy number 7.1 and last revised in January 2016 documented that "Individualized fall prevention interventions determined by the multidisciplinary team and level of fall risk will be documented by registered staff in the resident care plan. The resident care plan will include quantifiable, measurable goals with reassessment time frames and interventions with clear direction to guide the provision of care and treatment." Further, the policy stated that "The individualized resident fall risk care plan will be reviewed and updated quarterly, annually with the annual care conference, post fall and with any significant change in the resident condition."

In an interview with the Acting Director Of Care (ADOC), they shared that the Resident Assessment Instrument (RAI) Coordinator completed the admission assessments and care plans. The ADOC said that due to previous management direction, only the RAI Coordinator could update the care plans. Since the arrival of the new management team, they have been encouraging any registered staff members to update the care plan when needed and shared that the care plan should reflect the outcome of completed assessments and should have been updated when the resident returned from the hospital.

The licensee has failed to ensure that the plan of care for a specific resident was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls and other special needs. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 26. Whistle-blowing protection

Specifically failed to comply with the following:

s. 26. (5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2007, c. 8, s. 26 (5).
2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 2007, c. 8, s. 26 (5).
3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 2007, c. 8, s. 26 (5).
4. A staff member. 2007, c. 8, s. 26 (5).

Findings/Faits saillants :

1. The Licensee has failed to ensure that none of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c): 1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 4. A staff member.

During an inspection of a Critical Incident System report (CIS), Inspector #670 and Inspector #725 observed documentation regarding two incidents. Inspector #670 also observed documentation relating to a specific Registered Practical Nurse (RPN) being instructed to not report an incident to the Ministry of Health and Long-Term Care.

Review of the resident's clinical records showed that two specific incidents had occurred on two specific dates.

A late entry, progress note, in a specific resident's clinical record, dated for a specific date at a specific time, completed by a specific RPN stated; writer had called Director of Care last night in regards to a specific incident. Writer was told when asked, not to call the police or ministry. Writer was told to call the Power of Attorney's (POA's), and if a specific resident's POA wanted the police called then to do so. Writer was told to chart on the incident, to do a Risk Management, call both POA's, to do a Behavioral Supports Ontario (BSO) referral and a Social work referral.

On a specific date at a specific time an interview was conducted with the specific Registered Practical Nurse (RPN) who stated that the process in the home was to notify whatever nursing management was on call of any incidents. The RPN stated that on a specific date, they had notified the Director of Care at the time of the incident. The RPN stated that the DOC instructed them not to call the Ministry of Health and Long Term Care, not to call the police but to complete a risk management and notify the POA's. The RPN stated that they completed a late entry in the progress notes about the instruction the DOC had given them the next day due to the fact that when they came in for work they were told by other staff that management was looking for them and it was thought that it may have been related to the incident.

On a specific date at a specific time the documentation of the incidents as well as the documentation completed by the specific RPN were reviewed with the Executive Director (ED) who stated that the incidents should have been reported to the Ministry of Health and Long Term Care and that they had no knowledge of the Director of Care (DOC) instructing a staff member not to report the incident.

The Licensee has failed to ensure that none of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c): 1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract

described in section 110. 2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 4. A staff member. [s. 26. (5) 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 none of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c): 1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 4. A staff member, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system must, at minimum, provide for preparation of all menu items according to the planned menu and has failed to ensure that all food in the food production system was prepared and served using methods to preserve taste, nutritive value, appearance and food quality.

During stage one of the RQI, multiple residents identified concerns with the home’s food during resident interviews.

The home's policy, "Food Services - Meal Service" (Section 5.1), effective May 2017, stated meal items being served are those that appear on the menu, and that all foods listed on the therapeutic spreadsheets were available for service.

The home’s Winter Spring 2018- WEEK 1 menu was reviewed and indicated that Thursday’s breakfast was: assorted juice, oatmeal/bran, cream of wheat/bran, cottage cheese, apple spice muffin, assorted cold cereal, peanut butter, whole wheat toast, and apple jelly. The accompanying therapeutic list from Thursday of Week 1 of the Winter Spring 2018 menu listed pureed muffin under the Regular/Puree texture modification for breakfast.

On a specific date, the breakfast menu posted on the televisions throughout the home was: assorted juices, hot/cold cereal, cottage cheese, and a warm apple muffin or toast.

Breakfast was observed on a specific date, on a specific unit. After cereal was served, the food items observed in the servery and being served by a Dietary Aide (DA) were toast, pureed toast, cottage cheese, pureed cottage cheese, muffins, and yogurt. The Inspector observed various condiments being served to residents, including strawberry jam, but there was no apple jelly. The Inspector did not observe any pureed muffin in the servery. When asked if there was pureed muffin, DA #115 replied that none was provided to them.

A DA was interviewed on a specific date, and said that they had a therapeutic list to tell them what food item should be served for each modified-texture diet. The specific DA explained that they served breakfast earlier on a specific unit, and that they did not have pureed muffin. The specific DA said that residents were supposed to have a choice, but only had pureed toast. The DA acknowledged that they did notice that they did not receive any pureed muffin, but they did not call down to the kitchen. The DA added that when English muffins were on the menu in the past, they did not receive pureed English muffin to serve, but only pureed toast.

A Cook was interviewed on a specific date, and stated that there is a version of each menu item for all modified textures, including pureed. The Cook was unaware that pureed muffin was not provided at breakfast, but said that there should have been pureed muffin, and it would say on the therapeutic sheet if the pureed texture should have included the muffin.

A Cook was interviewed on a specific date, after breakfast and said that they forgot to puree muffins for breakfast, but that it was only forgotten for a specific unit and not the whole home. The Cook was interviewed again on a specific date, and acknowledged that pureed muffin was a scheduled item for breakfast the previous day, but that they forgot to puree muffins, and stated that the whole home did not get pureed muffin. The Cook explained that the version of each menu item for the modified textures was listed on the therapeutic sheet.

Director of Culinary Services (DCS) approached the Inspector on a specific date, and stated that they spoke with the Cook, who explained that they did not have time to puree the muffins. The DCS acknowledged that none of the units in the home received pureed muffins earlier that day for breakfast. [s. 72. (2) (d)]

2. During stage one of the RQI, multiple residents identified concerns with the home's food quality.

During resident interviews: two specific residents complained that the food was often cold; a specific resident complained that the minced meat was dry; a specific resident complained that the food did not look good; three specific residents complained about the taste of the food; three specific residents complained that the food was either overcooked or undercooked.

The home's policy, "Standardized Recipes" (Section 2.3), effective May 2017, stated that standardized recipes would be available and used by all staff involved in food production to provide safe food products and consistent quality. It also stated that the NM/RD/Designate ensured that standardized recipes included ingredients, a method/procedure, and instructions for making texture modified products. The policy said that the NM ensured that standardized recipes were readily available and used consistently by production staff.

The home's policy, "Food Tasting & Quality Evaluation" (Section 2.5), effective May

2017, stated that all food items served to residents, including texture modified foods, would be tasted and evaluated for acceptable quality by at least one person responsible for preparation or service of that food immediately prior to service. IT also stated that the cook/designate was able to modify the food using spices or slight adjustments to existing ingredients only, and that those adjustments were not to change the nutritional breakdown of the recipe or add any new ingredients/allergens.

The home's policy, "Food Services- Pleasurable Dining" (Section 5.3), effective May 2017, stated that appropriate and palatable food temperatures were to be maintained throughout meal service.

Breakfast was observed on a specific date, on a specific unit. A specific DA finished making toast at 0830 hours, and toast was observed being served to residents at 0920 hours. After breakfast, residents in the dining room were interviewed. Two specific residents said that the toast was not often hot, and that the home was aiming to save food costs, and it tasted like it, with some foods being bland and overcooked.

On the morning of a specific date, a specific DA was observed making pureed banana in the kitchen and said that the pureed banana was made with banana and lime juice to prevent browning, and that thickener was added if it was not thick enough. The DA reported that there was no recipe, but that they just added the lime juice and thickener as needed.

The home’s Winter Spring 2018- WEEK 1 menu was reviewed and indicated that a specific date's lunch was: cream of celery soup, unsalted crackers, shaved beef sandwich on wheat, mixed green salad with Italian dressing and raspberry gelatin, or herbed omelet, carrots, whole wheat bread, margarine, and a banana half.

On a specific date, Director of Culinary Services (DCS) provided the Inspector with copies of the standardized recipes for all menu items from breakfast and lunch on the specific date. The pureed banana recipe, “P. Banana Petite Fresh (P. Fresh Banana)”, listed two ingredients: banana petite fresh (peeled) and apple juice. All recipes were reviewed and none of them included thickener, breadcrumbs, instant mashed potatoes or crackers as ingredients. The standardized recipes for the two desserts, banana and raspberry gelatin, did not include whipped cream as an ingredient.

The Inspector obtained samples of foods that were being served on a specific date for lunch from a specific Cook who obtained foods, including modified-textures, from the hot

holding appliance prior to food being delivered up to the units. Inspectors #537 and #669 evaluated the appearance, quality, and taste of the foods and noted that: the carrots were mushy and overcooked; the pureed carrots were yellow compared to the regular ones; the minced and pureed roast beef tasted like mayonnaise rather than beef; the pureed banana tasted tangy or rotten. The Inspectors also noted that all of the pureed foods tasted starchy like raw flour, and did not taste like their regular-textured counterparts.

On a specific date at a specific time, DCS explained that orange juice was added to the pureed banana to prevent it from browning.

A specific DA was interviewed on a specific date, and said that, normally, toast was made and then they served it within 10-15 minutes. The DA explained that serving toast 50 minutes after making it was probably normal in some of the other dining rooms, and that they were sure that some residents would complain that it was cold. The DA said that they did not normally work in food preparation, but may be required to help puree or mince desserts. The DA continued that they were unsure if there were recipes, but that when pureeing fruit, for example, they would have to use majority fruit and blend it with thickener if needed. The DA added that they always put whipped cream on desserts when serving them to dress up the appearance.

A specific Cook was interviewed on a specific date, and stated that they tasted the food and followed the recipes which were computerized. The Cook continued that there were standardized recipes for all menus, and that they were followed by everybody, as far as they knew. The Cook said that there was a version of each menu item for all modified textures, and that for most pureed items, they blended the food and may need to add some water. The Cook added that if they wanted to thicken the puree, they would add thickener, instant mashed potatoes, breadcrumbs, or crackers, and that the amount added would be based on how the puree was thickening. The Cook stated they were not sure if thickening was part of the standardized recipes. On a specific date at a specific time, the tray of sample food provided tasted by the Inspectors was observed by the Cook. The Cook stated that the colour of the pureed carrots "looked off" and was not sure why they would be a different colour.

A Cook was interviewed on a specific date, and stated that when making pureed foods, their goals were to make the best product, that contained the right nutrients, and a smooth and consistent texture. The Cook said that ingredients were not normally added when pureeing foods, other than a dash of thickener to improve the consistency as

needed. Stated they monitored the consistency of pureed foods by checking it with spoon and allowing the food to run off and if needed they might add a touch of thickener to thicken it. The Cook said that they pureed the carrots and roast beef for lunch the previous day, and they only added margarine and parsley to the carrots and mayonnaise to the roast beef. The Cook explained that the other pureed items were done by another cook and dietary aide. The Cook shared that the home had standardized recipes for all menus in a book and on the computer, that the recipes were followed, and they were used to make sure foods were consistent across the board, no matter who made them. The Cook acknowledged that there were also standardized recipes for pureed foods, which listed all the ingredients and amounts to prepare a food item.

The Registered Dietitian (RD) was interviewed over the phone on a specific date and said that the home did have standardized recipes, and their purpose was to ensure that all recipes provided consistent products and consistent nutrients. The RD shared that the standardized recipes gave the nutrient content of the food items, which was used when completing the menu review, to make sure the home was meeting nutritional markers and dietary reference intakes. When asked if adding thickener, breadcrumbs, potato, or crackers to a recipe that were not contained in the standardized recipe would change the food item's nutritive value, taste, appearance, safety, or quality, RD said that it would add more carbohydrates, and that the thickener may make the food taste a little starchy. The RD said that it also may affect taste, for example, the food item may be saltier when adding crackers. The RD acknowledged the possibility of an allergen if a resident had a gluten intolerance and crackers or breadcrumbs were added to the recipe. The RD shared that the home has a resident who used to be on a gluten-intolerant diet, and was currently on a pureed diet. When asked if adding lime juice or orange juice to the pureed banana recipe instead of the apple juice that was indicated on the standardized recipe would change the food item's nutritive value, taste, appearance, safety, or quality, the RD said that there may be less vitamin C with the lime juice and that lime juice had less sugar, so the taste would definitely change with lime juice, and the pureed banana would be less sweet. When asked if adding whipping cream to desserts that was not indicated on the standardized recipe would change the food item's nutritive value, taste, appearance, safety, or quality, the RD said that it would add fat, and that if a resident had a milk allergy, it may pose a problem if the dessert did not already contain milk. The RD acknowledged that when food items were prepared without following the standardized recipes, it may affect the nutritive value, but it would depend on how much the actual preparation differed from the standardized recipe. The RD stated that preparing a recipe without following the standardized recipe may alter the taste or texture and may affect residents, and if an allergen was added that was not supposed to

be there, it may pose a risk for some residents.

The licensee failed to ensure that the food production system must, at minimum, provide for preparation of all menu items according to the planned menu and has failed to ensure that all food in the food production system was prepared and served using methods to preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

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 ensure that the food production system must, at a minimum, provide for, preparation of all menu items according to the planned menu and all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring.

During stage one of this RQI concerns regarding missing clothing was identified during resident interviews.

Review of a specific resident's clinical record stated that they were admitted on a specific date.

Observation of the laundry room at a specific time on a specific date, and the seamstress room on a specific date, showed that a Resident Admission form for the specific resident had been submitted to laundry and the seamstress stating that clothing needed to be labelled. None of the specific resident's clothing was present for labelling in the laundry room or the seamstress room.

Observation of the specific resident's room at a specific time on a specific date, showed one jacket, one pair of pajama pants, 3 sweaters, one short sleeved collared shirt and 3 pairs of jogging pants in the specific resident's room hanging in the armoire. All items were unlabeled.

The home's policy titled "Laundry Services", section 6-01, effective date January 2012 stated; the laundry services provided within the homes, at a minimum will include the following: Labelling of resident's personal items and clothing within 48 hours of admission.

On a specific date at a specific time the Environmental Supervisor acknowledged the specific resident's clothing was not labelled within 48 hours of admission and should have been.

The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring. [s. 89. (1) (a) (ii)]

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 as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Review of the home's medication incident reports for three specific months, showed a medication incident dated for a specific date. The medication incident report stated that a Registered Practical Nurse (RPN) had administered medications to a specific resident that were not ordered for the resident.

On a specific date at a specific time, an interview was conducted with the Acting Director of Nursing (ADOC) who stated that the specific resident had received medications that were not ordered for them and should not have received those medications.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the home's medication incident reports for three specific months, showed medication incidents dated for two specific dates.

a)The medication incident dated for a specific date, stated that a Registered Practical Nurse (RPN) had administered a specific amount of a specific drug to a specific resident on a specific date. The dose of the medication was double the ordered amount.

b)The medication incident dated for a specific date, stated that an RPN had signed the electronic Medication Administration Record (eMAR) as having administered a specific medication during the morning medication pass on a specific date. The medication was noted to still be in the card during count the next morning.

On a specific date at a specific time, an interview was conducted with Acting Director of Nursing (ADOC) who stated that drugs were not administered to two specific residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 o drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: 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 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: 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.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date regarding a specific incident.

Review of a specific resident's progress notes showed that the resident reported a specific incident on two specific dates. The initial report was three days prior to the the CIS being submitted and the second was one day prior to the CIS being submitted.

In an interview with a PSW, they shared that when they see or hear of incidents of abuse, they would immediately report it to their team lead or manager.

In an interview with two Registered Practical Nurses (RPN), they said when they receive reports of abuse resident safety needs to be ensured first, and then appropriate people are notified. They further shared that the MOHLTC, police, Executive Director (ED), Director of Care, physician and the substitute decision maker, if any, would all need to be notified as soon as possible.

The homes Abuse – Prevention, Elimination & Reporting Policy, last revised in May 2017, states that "All staff members are required to report witnessed or suspected abuse." Further explanation is provided in the Protocol for Reporting Allegations of Resident Abuse procedure section, which states that 1) Immediately report alleged, suspected or witnessed incidents to the Registered Staff member and 2) The Registered staff member must immediately contact the Administrator, Director of Nursing or delegate.

In an interview with the Executive Director (ED) they stated that the incident should have been reported immediately not three days after the resident reported to staff.

The licensee has failed to ensure that 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: 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. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

During an inspection of a Critical Incident System report (CIS) Inspector #670 observed documentation regarding two specific incidents.

Review of the specific resident's clinical records showed that specific incident's had occurred on two specific dates.

Inspector #670 was unable to locate a CIS for either incident. The home completed a search for a CIS and was unable to provide Inspector #670 with a CIS report for either incident.

The home's policy titled Abuse-Prevention, Elimination and Reporting Policy, last revised May 2017, stated The Administrator/Director of Nursing/Delegate will ensure the Ministry of Health and Long-Term Care is notified via telephone and shall complete a Critical Incident System report via the ltchomes.net website as required.

On a specific date at a specific time the Executive Director (ED) #100 stated that the home did not submit a CIS report and should have.

The licensee has failed to ensure that Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. [s. 104. (2)]

2. The licensee has failed to ensure that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. (in 21 days unless otherwise specified by the Director)

On April 5, 2018, while Inspectors #670 and #725 were reviewing the investigation notes for a separate Critical Incident System report (CIS), documentation was observed in the file related to an incident that occurred on a specific date, related to a specific incident. This was immediately stopped and reported by staff. Police were called. MOHLTC infoline was called, POA's and physician were called. Inspectors #670 and #725 observed an email from the Executive Director (ED) to the acting Director of Care (DOC) dated for a specific date, requesting specific information to update the CIS. There was an email observed from the acting DOC on a specific date, stating that the Ministry of Health (MOH) had called regarding the original call to the info line asking for the CIS and listed a phone number. There was an email observed from the ED to the acting DOC dated for, requesting that next time the Ministry of Health and Long-Term Care called that the acting DOC call or page the ED and also stated they were currently updating the CIS's and asked if the acting DOC was able to provide any information to the Ministry of Health and Long-Term Care when they called.

Review of a specific resident's progress notes showed that a specific incident had occurred on a specific date.

On a specific date at a specific time, the ED stated that the home did not submit a CIS report and should have.

The licensee has failed to ensure that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. (in 21 days unless otherwise specified by the Director) [s. 104. (3)]

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

Issued on this 12th day of June, 2018

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) :	DEBRA CHURCHER (670), ALICIA MARLATT (590), ANDREA DIMENNA (669), NANCY SINCLAIR (537)
Inspection No. / No de l'inspection :	2018_563670_0005
Log No. / No de registre :	002413-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 28, 2018
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 :	Nicole Ross

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. 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).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically the licensee must:
a) ensure identified residents and all other residents are protected from abuse by anyone and are not neglected by the licensee or staff.

Grounds / Motifs :

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

Ontario Regulation 79/10, s. 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) (c) of the Act, "physical abuse" means, "the use of physical force by a resident that causes physical injury to another resident."

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, describing a specific incident.

Review of a specific resident's progress notes showed that the resident was found in a specific position and another specific resident was in the vicinity.

Review of a specific residents progress notes showed documentation that the specific resident had made a specific statement.

Review of the home's risk management report completed for this incident, progress notes, and assessments, showed that a specific resident had sustained specific injuries as a result of the incident.

The CIS report documented that an investigation took place and they determined that a specific event had occurred.

In an interview with Executive Director (ED), they acknowledged that the specific event had occurred. [s. 19. (1)]

(590)

2. The home placed a call to the info line at a specific time on a specific date, and submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date at a specific time.

Review of a specific resident's clinical record and the home's submitted CIS report showed that a specific event had occurred on a specific date which resulted in specific injuries.

During an interview on a specific date with a specific resident the specific resident was able to recall the specific incident.

On a specific date at a specific time during an interview with the Executive Director they stated that they would consider this incident abuse. [s. 19. (1)]
(670)

3. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, describing a specific incident.

Review of a specific resident's progress notes showed that on a specific date the resident was found to have a specific injury.

The progress notes also showed that on a specific date a specific resident was found in a specific position with another specific resident in the area.

The CIS reports documented that investigations took place and they determined

that the specific incident had occurred.

In an interview with Executive Director (ED), they acknowledged that the specific incident had occurred resulting in injury to a specific resident.

The licensee has failed to ensure that residents were protected from abuse by anyone. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of this issue was a level 2 as it related to three of the seven incidents reviewed. The home had a level 3 history with a history of related non-compliance with this section of the LTCHA that included:
-voluntary plan of correction (VPC) issued May 30, 2017 (2017_262630_0013) (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_262630_0013, CO #001;

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 must be compliant with s. 20. (1) of the LTCHA.

Specifically the licensee must:

a) submit Critical Incident System reports and amend Critical Incident System reports within the time frames specified in the legislation.
b) comply with the licensee's written policy to promote zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection #2017_262630_0013, served on June 16, 2017, with a compliance date of September 29, 2017.

The licensee was ordered to ensure that the home's written policy to promote zero tolerance of abuse and neglect was 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.
The training provided to all staff must include sexual abuse. This training must accurately address consensual versus non-consensual touching, behaviours or

remarks of a sexual nature directed towards a resident by anyone including what is considered consensual for a resident with cognitive impairment and who can and cannot consent to these activities.

The licensee completed staff retraining and met all training requirements set out in the previous order.

The licensee has failed to ensure that 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.

The home's Abuse – Prevention, Elimination & Reporting Policy, last revised in May 2017, states that "All staff members are required to report witnessed or suspected abuse." Further explanation is provided in the Protocol for Reporting Allegations of Resident Abuse procedure section, which states that 1) Immediately report alleged, suspected or witnessed incidents to the registered staff member and 2) The registered staff member must immediately contact the Administrator, Director of Nursing or delegate.

A) Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, describing a specific concern from a specific resident regarding a specific incident.

Review of the specific resident's progress notes showed that the resident had reported incidents to staff on two occasions. One report was three days prior to the CIS being submitted and one was one day prior to the CIS being submitted.

In an interview with a specific PSW, they shared that when they see or hear of incidents of abuse, they would immediately report it to their team lead or manager.

In an interview with two specific Registered Practical Nurses, they said when they receive reports of abuse, resident safety needs to be ensured first, and then appropriate people are notified. They further shared that the MOHLTC, police, Executive Director (ED), Director of Care, physician and the substitute decision maker, if any, would all need to be notified as soon as possible.

In an interview with the ED, they stated that the incident should have been reported on a specific date to the ED, police, MOHLTC and any Substitute Decision Makers and was not.

B) The home's policy titled Abuse-Prevention, Elimination and Reporting Policy, last revised May 2017, stated, "All staff members are required to report witnessed or suspected abuse. The Administrator/Director of Nursing/Delegate will ensure the Ministry of Health and Long-Term Care is notified via telephone and shall complete a Critical Incident System report via the ltchomes.net website as required".

During an inspection of a Critical Incident System report (CIS), Inspector #670 observed documentation regarding an internal investigation into two specific incidents involving two specific residents. The original CIS being inspected had not involved the two specific residents.

Review of the two specific resident's clinical records showed that on two specific dates there were incident's involving two specific residents.

Inspector #670 was unable to locate a CIS for either incident. The home completed a search for a CIS and was unable to provide Inspector #670 with a CIS report for either incident.

On a specific date at a specific time the ED stated that the home did not submit a CIS report and should have.

C) The home's policy titled Abuse-Prevention, Elimination and Reporting Policy, last revised May 2017, stated, "All staff members are required to report witnessed or suspected abuse. The Administrator/Director of Nursing/Delegate will ensure the Ministry of Health and Long-Term Care is notified via telephone and shall complete a Critical Incident System report via the ltchomes.net website as required."

On April 5, 2018, while Inspectors #670 and #725 were reviewing the investigation notes for a separate Critical Incident System report (CIS), documentation was observed in the file related to an incident that occurred on a specific date, related to a specific incident. This was immediately stopped and reported by staff. Police were called. MOHLTC infoline was called, POA's and physician were called. Inspectors #670 and #725 observed an email from the

Executive Director (ED) to the acting Director of Care (DOC) dated for a specific date, requesting specific information to update the CIS. There was an email observed from the acting DOC on a specific date, stating that the Ministry of Health (MOH) had called regarding the original call to the info line asking for the CIS and listed a phone number. There was an email observed from the ED to the acting DOC dated for, requesting that next time the Ministry of Health and Long-Term Care called that the acting DOC call or page the ED and also stated they were currently updating the CIS's and asked if the acting DOC was able to provide any information to the Ministry of Health and Long-Term Care when they called.

Review of a specific resident's progress notes showed that a specific incident had occurred on a specific date.

On a specific date at a specific time, the ED stated that the home did not submit a CIS report and should have.

The licensee has failed to ensure that 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. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of this issue was a level 2 as it related to three of the seven incidents reviewed. The home had a level 4 history as the had on-going non-compliance with this section of the LTCHA that included:
-voluntary plan of correction (VPC) issued April 20, 2016 (2016_262523_0018)
-VPC issued February 21, 2017 (2017_418615_0002)
-compliance order (CO) issued May 30, 2017 (2017_262630_0013)
(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2018

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

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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Name of Inspector / Nom de l'inspecteur : Debra Churcher

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