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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 11, 2019	2019_508137_0004	028103-18, 028368-18, 028755-18, 029684-18, 031444-18, 031588-18, 031589-18, 031590-18	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

MARIAN MACDONALD (137), 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): February 5-8, 11-15 and 19 -21, 2019.

The following intakes were completed within this inspection:

Complaint Log #028103-18 and IL-61088-LO related to staffing shortages, bathing,

continence care and sleep or rest routines.
Complaint Log #028368-18 and IL-61150-LO related to staffing shortages and toileting.
Complaint Log #028755-18 and IL-61282-LO related to staffing shortages, resident care provision and medication administration.
Complaint Log #029684-18 and IL-61544-LO related to staffing shortages resulting in neglect of residents.
Complaint Log #031444-18 and IL-62163-LO related to medication administration.
Three Follow Up inspections were also completed concurrently with this Complaint Inspection:
Compliance Order #001 and Log #031588-18 related to the staffing mix not consistent with the residents' assessed care and safety needs.
Compliance Order #002 related to not having a Registered Nurse on duty and present in the home at all times.
Compliance Order #003 related to not having an annual evaluation of the staffing plan.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Clinical Services, Associate Director of Clinical Services, Director of Business Services, Director of Programs and Support Services, Employee Services Coordinator, Resident Assessment Instrument (RAI) Coordinators, Vice-President of Quality and Strategic Direction, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), Dietary Aides, Housekeepers, Family members and residents.

The inspectors also toured the home, observed several meal services, medication administration, resident care provision, staff to resident interactions, reviewed residents' clinical records, relevant policies and procedures, meeting minutes, staffing schedules and internal investigation records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Medication
Personal Support Services
Sufficient Staffing

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

- **8 WN(s)**
- **3 VPC(s)**
- **5 CO(s)**
- **2 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. 31. (4)	CO #003	2018_607523_0026	137

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	Légende 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. 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 at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

Compliance Order #002 was issued on November 2, 2018 with a compliance date of November 30, 2018, following a Complaint Inspection. The Compliance Order stated that "The licensee shall ensure the following:
Develop, document and implement a process in the home to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times".

In addition, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) Infoline, IL-61544-LO, related to not always having a Registered Nurse in the home.

A) A review of the Registered Nurse (RN) staffing schedules from January 2-31, February 2-3 and 10-20, 2019 showed that the home did not have 24/7 RN coverage for 19 of 43 (44 per cent) full or partial shifts. The shifts were covered by Registered Practical Nurses (RPN).
During an interview, the Executive Director (ED) #001 and Director of Clinical Services (DOCS) #102 said that they were aware of the RN shortage and continued to recruit.

B) During a review of the "Medication Administration Audit Report" in Point Click Care, with DOCS #102 and Associate Director of Clinical Services (ADOCS) #123, it showed multiple late administration of time specific medications. The report showed several medications administered from one to four hours later than the scheduled administration time.
Both DOCS #102 and ADOCS #123 said when they were short a registered staff person and could not find a replacement, another registered staff on duty would be directed to administer medications on two floors, which resulted in late medication administration.
DOCS #102 said it was the expectation that medication be administered within the hour, as ordered by the physician.

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

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Compliance Order #001 was issued on November 2, 2018, under Inspection #2018_607523_0026, with a compliance due date of December 31, 2018, following a Complaint Inspection. The Compliance Order stated that the licensee was to:
"a) Develop, document and implement a process in the home to identify the assessed care and safety needs of the residents in each home area; and a corrective action plan to

ensure that all residents receive their assessed care and safety needs including but not limited to: bathing twice per week by the method of their choice, transferring and positioning, releasing and reapplying restraints and/or PASDs, toileting, proper, timely and safe service and assistance for meals and responding to resident-staff communication and response system. Records for these audits are to be maintained.
b) Ensure that all nursing and personal support staff are educated on the home's documentation policy including documentation in Point of Care and Point Click Care".

The licensee failed to complete steps a) and b) of the Compliance Order.

In addition, four complaints were submitted to the Ministry of Health and Long-Term Care (MOHLTC) Infoline, IL-61150-LO, IL-61282-LO, IL-61544-L_ and IL-62163-LO, related to short staffing affecting care provision and medication administration.

A) A review of the Personal Support Worker (PSW) schedules between January 1 and February 3, 2019, showed that the home worked without one or more PSWs for 45 either full or partial shifts.
DOCS #102 and Employee Services Coordinator #107 said they were aware of the challenges with staffing and the shortages had a negative impact on the provision of resident care.

B) On February 5, 2019, Executive Director (ED) #101 and Director of Clinical Services (DOCS) #102 said they thought the workload for the bathing care was manageable for the staff. DOCS #102 said they would be notified of missed baths through an email and that they thought any missed bath would be rescheduled. DOCS #102 said that some residents had been receiving bed baths as indicated on the bathing documentation form.
The Point Click Care (PCC) "Follow-up Question Report" was provided by ED #101 which they said summarized the bathing care for residents in the home. A record review of the PCC "Follow-up Question Report" dated February 5, 2019, for each area of the home was reviewed and showed that between January 1 and February 3, 2019, 94 out of 128 (74 per cent) residents listed on this report were not provided their two preferred baths once per week during this time frame.
The PCC "Clinical and Order Alerts Report" showed that in the home between January 1 and February 3, 2019, at least 37 baths were documented with an alert that the bath was not done due to work "overload."
DOCS #102 said that they had not been auditing the completion of baths on a regular basis using the PCC "Follow-up Question Report" and was relying on the emails from staff to track the baths that were not completed.

C) The Residents' Council meeting minutes for January 9, 2019, identified a concern that mealtimes were not starting on time. The documented "immediate action" was that the Director of Culinary Services stated that management was aware of the concern and were looking for strategies to "get meal times back on track." The "recommendation to prevent recurrence" was that a manager would check each unit for staffing levels and email management with a daily update. This notifies management to which floors may need additional assistance for the morning to catch up."

Throughout the inspection, the Inspectors conducted several mealtime observations, which showed residents did not receive their meal and assistance in a timely manner, especially at the breakfast meal. Observations on a specific date showed three residents receiving their breakfast meal between more than two hours after the the meal started, as other residents were entering the dining room for lunch.

Based on these observations and interviews, the staffing plan of home did not provide for a staffing mix that was consistent with residents' assessed care and safety needs at mealtimes. The staffing mix did not ensure that residents were consistently being provided meal service at the established mealtimes within the home. The PSW staff were consistently not available to assist residents with their mealtime care during breakfast meals.

D) The "Call Bell Response Record" report was provided by Executive Director (ED) #101 for the time period of January 1 to February 3, 2019. On an identified date, the report showed the response times, between 0310 hours and 0708 hours, ranged from 32 minutes to over five hours. Eight response times were one hour or more. A review of the staffing shortages showed that the home was short two full PSW shifts on that particular shift.

A review of the "Call Bell Response Record" report showed that, on 18 separate occasions, one identified resident had to wait thirty minutes or more for staff to respond to their call bell, a second identified resident had to wait ten minutes or more daily for staff to respond to their call bell and on four separate occasions this resident had to wait thirty minutes or more for staff to respond to their call bell, a third identified resident, on ten separate occasions, had to wait ten minutes or more for staff to respond to their call bell and a fourth identified resident said they have waited over an hour for staff to respond to their call bell. Interviews with residents and family showed that there were times when call bells were not responded to in a timely manner, resulting in incontinence

episodes, causing discomfort and embarrassment to the residents.

During an interview, a staff member said the expectation in the home was to answer call bells as fast as possible but at times the staff were not able to respond as quickly as they would like and that it was difficult to respond to the call bells at times if they were already assisting other residents in their rooms with care or assisting in the dining rooms at meals.

DOCS #102 said call bell response records were not audited and only reviewed if a resident or family member lodged a complaint or raised a concern about having to wait for assistance.

E) Observations, interviews and record reviews conducted throughout the inspection showed seven identified residents did not always receive toileting or continence care assistance from staff to manage and maintain continence, as a result of staffing shortages.

F) During a review of the "Medication Administration Audit Report" in Point Click Care, with DOCS #102 and Associate Director of Clinical Services (ADOCS) #123, it showed multiple late administration of time specific medications. The report showed several medications administered from 1 to 4 hours later than the scheduled administration time.

During interviews, several registered staff expressed concern as they had frequently been responsible for administering medications for two floors, due to staffing shortages, which resulted in late medication administration, medication errors, risk to residents and jeopardized their nursing license.

Both DOCS #102 and ADOCS #123 said when they were short a registered staff person and could not find a replacement, another registered staff on duty would be directed to administer medications on two floors, which resulted in late medication administration. Both said there was no audit completed or no formal process for tracking late medication administration.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) The Ministry of Health and Long-Term Care (MOHLTC) Action Line received a complaint IL-61088-LO, related to residents not receiving their baths due to the staffing levels in the home.

On February 5, 2019, Executive Director (ED) #101 and Director of Clinical Services (DOCS) #102 said they thought the workload for the bathing care was manageable for the staff. DOCS #102 said they would be notified of missed baths through an email and that they thought any missed bath would be rescheduled. DOCS #102 said that some residents had been receiving bed baths as indicated on the bathing documentation form.
The Point Click Care (PCC) "Follow-up Question Report" was provided by ED #101 which they said summarized the bathing care for residents in the home. A record review of the PCC "Follow-up Question Report" dated February 5, 2019, for each area of the home was reviewed and showed that between January 1 and February 3, 2019, 94 out of 128 (74 per cent) residents listed on this report were not provided their two preferred baths once per week during this time frame.
The PCC "Clinical and Order Alerts Report" showed that in the home between January 1 and February 3, 2019, at least 37 baths were documented with an alert that the bath was not done due to work "overload."
DOCS #102 said that they had not been auditing the completion of baths on a regular basis using the PCC "Follow-up Question Report" and was relying on the emails from staff to track the baths that were not completed.

Interviews with residents, family members, staff, clinical record reviews and observations showed that the licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Observations, interviews and record reviews conducted throughout the inspection showed seven identified residents did not always receive toileting or continence care assistance from staff to manage and maintain continence. Residents said incontinence episodes caused them discomfort and embarrassment.

During interviews, several PSWs said when they were short staffed in the home, it did affect continence care provided to residents and sometimes residents had to wait up to half an hour for assistance from staff with toileting or to be changed. They said that they were doing their best to prioritize care for the residents but residents were having to wait for care, which sometimes resulted in residents being incontinent.

Interviews with residents, family members, staff, clinical record reviews and observations showed that the licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence and failed to ensure residents had sufficient changes of continence care products to remain clean, dry and comfortable. [s. 51. (2) (c)] [s. 51. (2) (g)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (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 drugs were administered to residents in accordance for use specified by the prescriber.

During a review of the "Medication Administration Audit Report" in Point Click Care, a random selection of 16 residents who were prescribed various medications and administration times, showed all (100 per cent) residents were administered their medications up to 4+ hours later than the scheduled administration time. Several of the medications were time specific and the late administration had the potential to cause significant risk and harm to the residents.

During interviews, several registered staff expressed concern as they had frequently been responsible for administering medications for two floors, due to staffing shortages, which resulted in late medication administration, medication errors, risk to residents and jeopardized their nursing license.

During an interview, both DOCS #102 and ADOCS #123 said when they were short a registered staff person and could not find a replacement, another registered staff on duty would be directed to administer medications on two floors, which resulted in late medication administration.

DOCS #102 said due to the close time proximity between the morning and noon medication administration passes, there were times when the Physician was contacted

and orders were received to hold the noon medications for some residents. DOCS #102 confirmed these would be considered medication errors or omissions but were not recorded as medication errors or omissions.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) Infoline, IL-62163-LO, related to late medication administration for an identified resident. A review of the Medication Administration Audit Report showed medications were administered six hours later than the prescribed the scheduled time.

DOCS #102 said it was the expectation that medication be administered within the hour, as ordered by the physician, as late medication administration had the potential to cause potential risk and harm to residents.

The licensee has failed to ensure that drugs were administered to residents in accordance for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the toileting care set out in the plan of care was based on an assessment of the resident and the needs of that resident.

The Ministry of Health and Long-Term Care (MOHLTC) Action Line received complaint IL-61088-LO related to an identified resident not receiving the care they required for continence care and toileting. Concerns were expressed about the length of time the residents had to wait for assistance from staff, specifically related to continence care and toileting.

Interviews with residents, family members, staff, clinical record reviews and observations showed that the licensee has failed to ensure that the toileting plan of care for an identified resident was not based on the most recent assessments of continence care and transfer status and was not based on the current needs of that resident. [s. 6. (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 the toileting care set out in the plan of care was based on an assessment of the resident and the needs of that resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of sleep patterns and preferences.

During an interview, an identified resident said that they sometimes had to wait a long time to go to bed at night. Sometimes staff were not able to assist them to bed for over two hours later than their preferred time.

A review of the identified resident's plan of care showed there was no documented evidence that the plan included the resident's sleep preferences.

ED #101 acknowledged that bedtime preferences would need to be assessed and included in the plan of care for staff to know if residents required specific bedtime care as part of their routines.

Interviews with residents, staff, clinical record reviews and observations showed that the licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of sleep patterns and preferences. [s. 26. (3) 21.]

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, at a minimum, an interdisciplinary assessment of sleep patterns and preferences, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) drugs are stored in an area or a medication cart (ii) that was secured and locked.

Inspectors #137 and #630 observed a medication cart locked but unattended. On top of the cart there were two time specific medications. One was labeled for an identified resident and the other was not labeled. There was one resident seated within close proximity to the medication cart. The registered staff member said they were not aware that these medications could not be left on top of the medication cart.

During an interview, ED #101, DOCS #102 and ADOCS #123 said medications were to be properly labeled and stored in the locked medication cart, when the cart was unattended.

The licensee has failed to ensure that, (a) drugs are stored in an area or a medication cart (ii) that was secured and locked. [s. 129. (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 drugs were stored in an area or a medication cart that was secured and locked, to be implemented voluntarily.

Issued on this 29th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) :	MARIAN MACDONALD (137), AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2019_508137_0004
Log No. / No de registre :	028103-18, 028368-18, 028755-18, 029684-18, 031444-18, 031588-18, 031589-18, 031590-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 11, 2019
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

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

Ministère 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

To Copper Terrace Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_607523_0026, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.8 (3) of the LTCHA.
Specifically, the licensee shall ensure the following:

a) Develop, implement and document a process in the home 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.
b) The licensee must complete a comprehensive assessment of registered staffing plans to achieve compliance with LTCHA, 2007, S.O.2007, c.8, s.8 (3). Once the assessment is completed, strategies to hire staff must be pursued to ensure that there is a back-up plan in place for registered nursing staff that addresses situations when staff cannot come to work, strategies are to be documented and maintained in the home.
c) Registered staff are available to administer all medications to all residents in accordance with use specified by the prescriber.

Grounds / Motifs :

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

Compliance Order #002 was issued on November 2, 2018 with a compliance date of November 30, 2018, following a Complaint Inspection. The Compliance

Order stated that "The licensee shall ensure the following:
Develop, document and implement a process in the home to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times".

In addition, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) Infoline, IL-61544-LO, related to not always having a Registered Nurse in the home.

A) A review of the Registered Nurse (RN) staffing schedules from January 2-31, February 2-3 and 10-20, 2019 showed that the home did not have 24/7 RN coverage for 19 of 43 (44 per cent) full or partial shifts. The shifts were covered by Registered Practical Nurses (RPN).
During an interview, the Executive Director (ED) #001 and Director of Clinical Services (DOCS) #102 said that they were aware of the RN shortage and continued to recruit.

B) During a review of the "Medication Administration Audit Report" in Point Click Care, with DOCS #102 and Associate Director of Clinical Services (ADOCS) #123, it showed multiple late administration of time specific medications. The report showed several medications administered from one to four hours later than the scheduled administration time.
Both DOCS #102 and ADOCS #123 said when they were short a registered staff person and could not find a replacement, another registered staff on duty would be directed to administer medications on two floors, which resulted in late medication administration.
DOCS #102 said it was the expectation that medication be administered within the hour, as ordered by the physician.

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

The severity of this area of non-compliance was determined to be a level 3 as there was actual harm or risk to residents. The scope was determined to be a level 3, widespread, as it affected all residents in the home.

The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification, Compliance Order and Director Referral on November 2, 2018, under Inspection #2018_607523_0026, during a Complaint Inspection;
Written Notification and a Voluntary Plan of Correction on May 28, 2018, under Inspection #2018_563670_0005, during a Resident Quality Inspection (RQI).

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2018_607523_0026, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with s. 31(3) of O.Reg.79/10.

The licensee shall prepare, submit and implement a plan for achieving compliance with O.Reg.s.31(3)(a) to ensure the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs, specifically:

a) Complete a comprehensive assessment of staffing plans to achieve compliance with Reg.79/10, s. 31 (3). Once the assessment is done, strategies to hire staff must be pursued to ensure that there is a back-up plan in place for nursing and personal care staff that safely addresses situations when staff cannot come to work.
b) Develop, implement and document a process in the home to identify the assessed care and safety needs of the residents in each home area.
c) Develop an action plan, including weekly audits and the person(s) responsible for completing the audits, to ensure that all residents receive their assessed care and safety needs including but not limited to receiving baths twice per week by the method of their choice; proper, timely and safe service and assistance for meals; responding in a timely manner to the resident-staff communication and response system; receiving timely toileting/continence care assistance; medications administered for use as per the prescriber.
d) Any concerns or deficiencies identified in the audits shall be monitored, analyzed, and evaluated to improve the quality of care and services provided to the residents of the long-term care home. The audits shall be documented and kept in the home.
e) Ensure that all nursing and personal support staff are educated on the home's documentation policy including documentation in Point of Care (POC) and Point Click Care (PCC), especially as it is related to bathing documentation. Identify who will be responsible for providing the education and when it will be provided. The education records are to be documented and kept in the home.

Please submit the written plan for achieving compliance for, 2019_508137_0004 to Marian C. Mac Donald, LTC Homes Inspector, MOHLTC, by email to LondonSAO.moh@ontario.ca by March 25, 2019.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Compliance Order #001 was issued on November 2, 2018, under Inspection #2018_607523_0026, with a compliance due date of December 31, 2018, following a Complaint Inspection. The Compliance Order stated that the licensee was to:
"a) Develop, document and implement a process in the home to identify the assessed care and safety needs of the residents in each home area; and a corrective action plan to ensure that all residents receive their assessed care and safety needs including but not limited to: bathing twice per week by the method of their choice, transferring and positioning, releasing and reapplying restraints and/or PASDs, toileting, proper, timely and safe service and assistance for meals and responding to resident-staff communication and response system. Records for these audits are to be maintained.
b) Ensure that all nursing and personal support staff are educated on the home's documentation policy including documentation in Point of Care and Point Click Care".

The licensee failed to complete steps a) and b) of the Compliance Order.

In addition, four complaints were submitted to the Ministry of Health and Long-Term Care (MOHLTC) Infoline, IL-61150-LO, IL-61282-LO, IL-61544-L_ and IL-62163-LO, related to short staffing affecting care provision and medication administration.

A) A review of the Personal Support Worker (PSW) schedules between January 1 and February 3, 2019, showed that the home worked without one or more PSWs for 45 either full or partial shifts.
DOCS #102 and Employee Services Coordinator #107 said they were aware of the challenges with staffing and the shortages had a negative impact on the provision of resident care.

B) On February 5, 2019, Executive Director (ED) #101 and Director of Clinical Services (DOCS) #102 said they thought the workload for the bathing care was manageable for the staff. DOCS #102 said they would be notified of missed baths through an email and that they thought any missed bath would be

rescheduled. DOCS #102 said that some residents had been receiving bed baths as indicated on the bathing documentation form. The Point Click Care (PCC) "Follow-up Question Report" was provided by ED #101 which they said summarized the bathing care for residents in the home. A record review of the PCC "Follow-up Question Report" dated February 5, 2019, for each area of the home was reviewed and showed that between January 1 and February 3, 2019, 94 out of 128 (74 per cent) residents listed on this report were not provided their two preferred baths once per week during this time frame.
The PCC "Clinical and Order Alerts Report" showed that in the home between January 1 and February 3, 2019, at least 37 baths were documented with an alert that the bath was not done due to work "overload."
DOCS #102 said that they had not been auditing the completion of baths on a regular basis using the PCC "Follow-up Question Report" and was relying on the emails from staff to track the baths that were not completed.

C) The Residents' Council meeting minutes for January 9, 2019, identified a concern that mealtimes were not starting on time. The documented "immediate action" was that the Director of Culinary Services stated that management was aware of the concern and were looking for strategies to "get meal times back on track." The "recommendation to prevent recurrence" was that a manager would check each unit for staffing levels and email management with a daily update. This notifies management to which floors may need additional assistance for the morning to catch up."

Throughout the inspection, the Inspectors conducted several mealtime observations, which showed residents did not receive their meal and assistance in a timely manner, especially at the breakfast meal. Observations on a specific date showed three residents receiving their breakfast meal between more than two hours after the the meal started, as other residents were entering the dining room for lunch.

Based on these observations and interviews, the staffing plan of home did not provide for a staffing mix that was consistent with residents' assessed care and safety needs at mealtimes. The staffing mix did not ensure that residents were consistently being provided meal service at the established mealtimes within the home. The PSW staff were consistently not available to assist residents with their mealtime care during breakfast meals.

D) The "Call Bell Response Record" report was provided by Executive Director (ED) #101 for the time period of January 1 to February 3, 2019. On an identified date, the report showed the response times, between 0310 hours and 0708 hours, ranged from 32 minutes to over five hours. Eight response times were one hour or more. A review of the staffing shortages showed that the home was short two full PSW shifts on that particular shift.

A review of the "Call Bell Response Record" report showed that, on 18 separate occasions, one identified resident had to wait thirty minutes or more for staff to respond to their call bell, a second identified resident had to wait ten minutes or more daily for staff to respond to their call bell and on four separate occasions this resident had to wait thirty minutes or more for staff to respond to their call bell, a third identified resident, on ten separate occasions, had to wait ten minutes or more for staff to respond to their call bell and a fourth identified resident said they have waited over an hour for staff to respond to their call bell. Interviews with residents and family showed that there were times when call bells were not responded to in a timely manner, resulting in incontinence episodes, causing discomfort and embarrassment to the residents.

During an interview, a staff member said the expectation in the home was to answer call bells as fast as possible but at times the staff were not able to respond as quickly as they would like and that it was difficult to respond to the call bells at times if they were already assisting other residents in their rooms with care or assisting in the dining rooms at meals.

DOCS #102 said call bell response records were not audited and only reviewed if a resident or family member lodged a complaint or raised a concern about having to wait for assistance.

E) Observations, interviews and record reviews conducted throughout the inspection showed seven identified residents did not always receive toileting or continence care assistance from staff to manage and maintain continence, as a result of staffing shortages.

F) During a review of the "Medication Administration Audit Report" in Point Click Care, with DOCS #102 and Associate Director of Clinical Services (ADOCS)

#123, it showed multiple late administration of time specific medications. The report showed several medications administered from 1 to 4 hours later than the scheduled administration time.

During interviews, several registered staff expressed concern as they had frequently been responsible for administering medications for two floors, due to staffing shortages, which resulted in late medication administration, medication errors, risk to residents and jeopardized their nursing license.

Both DOCS #102 and ADOCS #123 said when they were short a registered staff person and could not find a replacement, another registered staff on duty would be directed to administer medications on two floors, which resulted in late medication administration. Both said there was no audit completed or no formal process for tracking late medication administration.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

The severity of this area of non-compliance was determined to be a level 3 as there was actual harm or risk to residents. The scope was determined to be a level 3, widespread, as it affected all residents in the home.
The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification, Compliance Order and Director Referral on November 2, 2018, under Inspection #2018_607523_0026, during a Complaint Inspection;
Written Notification and a Voluntary Plan of Correction on August 1, 2018, under Inspection #2018_536537_0019, during a Complaint Inspection;
Written Notification and a Voluntary Plan of Correction on March 29, 2017, under Inspection #2017_566669_0004, during a Complaint Inspection;

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

Ministère 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

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg.79/10, s. 33(1).
Specifically, the licensee shall ensure the following:

a) All residents are bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
b) That a procedure for tracking, monitoring and documenting all residents bathing, including missed bathing, is developed and implemented including who will be responsible.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) The Ministry of Health and Long-Term Care (MOHLTC) Action Line received a complaint IL-61088-LO, related to residents not receiving their baths due to the staffing levels in the home.

On February 5, 2019, Executive Director (ED) #101 and Director of Clinical Services (DOCS) #102 said they thought the workload for the bathing care was manageable for the staff. DOCS #102 said they would be notified of missed baths through an email and that they thought any missed bath would be rescheduled. DOCS #102 said that some residents had been receiving bed

baths as indicated on the bathing documentation form. The Point Click Care (PCC) "Follow-up Question Report" was provided by ED #101 which they said summarized the bathing care for residents in the home. A record review of the PCC "Follow-up Question Report" dated February 5, 2019, for each area of the home was reviewed and showed that between January 1 and February 3, 2019, 94 out of 128 (74 per cent) residents listed on this report were not provided their two preferred baths once per week during this time frame.
The PCC "Clinical and Order Alerts Report" showed that in the home between January 1 and February 3, 2019, at least 37 baths were documented with an alert that the bath was not done due to work "overload."
DOCS #102 said that they had not been auditing the completion of baths on a regular basis using the PCC "Follow-up Question Report" and was relying on the emails from staff to track the baths that were not completed.
(630)

2. One identified resident did not receive their baths twice per week and this had occurred several times over the past month. (630)

3. A second identified resident did not receive their two baths per week and preferred to have a shower but was usually given a bath. (630)

4. A third identified resident said they did not receive their two baths per week. (630)

5. A fourth identified resident said they had been receiving one or fewer baths per week. (630)

6. A fifth identified resident said they did not always receive their two baths each week and the baths could be very sporadic. (630)

7. Identified residents said they were not bathed by the method of their preferred choice, as bed baths were often given rather than a tub bath or shower.

Interviews with residents, family members, staff, clinical record reviews and observations showed that the licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

The severity of this area of non-compliance was determined to be a level 2, minimal harm or potential for actual harm. The scope was determined to be a level 3, widespread, as it affected several residents in the home.
The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification and a Voluntary Plan of Correction on August 1, 2018, under Inspection #2018_536537_0019, during a Complaint Inspection. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with O.Reg.79/10,s.51.
Specifically, the licensee shall ensure that:

a) All residents who are unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence
b) All residents are provided with the continence care they require to ensure they have sufficient changes of continence care products to remain clean, dry and comfortable.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Observations, interviews and record reviews conducted throughout the inspection showed seven identified residents did not always receive toileting or continence care assistance from staff to manage and maintain continence. Residents said incontinence episodes caused them discomfort and embarrassment.

During interviews, several PSWs said when they were short staffed in the home, it did affect continence care provided to residents and sometimes residents had to wait up to half an hour for assistance from staff with toileting or to be changed. They said that they were doing their best to prioritize care for the residents but residents were having to wait for care, which sometimes resulted in residents being incontinent. (630)

2. One identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence. (630)

3. A second identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence. (630)

4. A third identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain

continence.
(630)

5. A fourth identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence. (630)

6. A fifth identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence. (630)

7. A sixth identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence. (630)

8. A seventh identified resident who was unable to toilet independently some or all of the time did not receive assistance from staff to manage and maintain continence.

Interviews with residents, family members, staff, clinical record reviews and observations showed that the licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence and failed to ensure residents had sufficient changes of continence care products to remain clean, dry and comfortable. [s. 51. (2) (c)] [s. 51. (2) (g)]

The severity of this area of non-compliance was determined to be a level 2, minimal harm or potential for actual harm. The scope was determined to be a level 3, widespread, as it affected several residents in the home.
The home does not have a history of non-compliance in this subsection of the Legislation. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg.79/10,s.131(2).
Specifically, the licensee shall ensure that:

a) All medications are administered to all residents in accordance for use specified by the prescriber.
b) That a procedure for tracking and monitoring medication administration times is developed and implemented, including who will be responsible.

Grounds / Motifs :

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

During a review of the "Medication Administration Audit Report" in Point Click Care, a random selection of 16 residents who were prescribed various medications and administration times, showed all (100 per cent) residents were administered their medications up to 4+ hours later than the scheduled administration time. Several of the medications were time specific and the late administration had the potential to cause significant risk and harm to the residents.

During interviews, several registered staff expressed concern as they had frequently been responsible for administering medications for two floors, due to staffing shortages, which resulted in late medication administration, medication errors, risk to residents and jeopardized their nursing license.

During an interview, both DOCS #102 and ADOCS #123 said when they were short a registered staff person and could not find a replacement, another

registered staff on duty would be directed to administer medications on two floors, which resulted in late medication administration.

DOCS #102 said due to the close time proximity between the morning and noon medication administration passes, there were times when the Physician was contacted and orders were received to hold the noon medications for some residents. DOCS #102 confirmed these would be considered medication errors or omissions but were not recorded as medication errors or omissions.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) Infoline, IL-62163-LO, related to late medication administration for an identified resident. A review of the Medication Administration Audit Report showed medications were administered six hours later than the prescribed the scheduled time.

DOCS #102 said it was the expectation that medication be administered within the hour, as ordered by the physician, as late medication administration had the potential to cause potential risk and harm to residents.

The licensee has failed to ensure that drugs were administered to residents in accordance for use specified by the prescriber. [s. 131. (2)]

The severity of this area of non-compliance was determined to be a level 3, actual harm or risk. The scope was determined to be a level 3, widespread, as it affected several residents in the home.
The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification and a Voluntary Plan of Correction on May 28, 2018, under Inspection #2018_563670_0005, during a Resident Quality Inspection. (RQI)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

(137)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 11th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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