Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 14, 2019	2019_563670_0041	021543-19	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 12 and 13, 2019.

The purpose of this inspection was to inspect Log#021543-19 CIS#1115-000060-19 related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, the Director of Dietary Services, one Environmental Service Worker, one Registered Practical Nurse Behavior Supports Ontario Lead, two Registered Practical Nurses and two Personal Support Workers.

During the course of this inspection the inspector observed the overall cleanliness and maintenance of the home, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records, reviewed relevant internal investigation records, reviewed relevant internal policies and procedures and reviewed relevant employee files.

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 resident #002 was protected from abuse by resident #001.

On a specific date, the home submitted a Critical Incident System report (CIS) to the Ministry of Long-Term Care (MOLTC) related to an incident involving resident#001 and #002.

An interview was conducted on a specific date, with Registered Practical Nurse (RPN) #102. Stated that they are the split nurse and splits their time between two units. RPN #102 stated that on a specific date, resident #002 was their resident for medications. RPN #102 shared that on a specific date at a specific time resident #002 was not in a specific location that RPN #102 expected resident #002 to be. As they were about to go and look for resident #002 a Personal Support Worker (PSW) #109 stated that resident #001 was also not in a specific location where they would expect resident #001 to be. RPN #102 went looking and found both residents in a specific location and RPN #102 observed a specific incident in progress.

RPN #102 stated that resident #002 was assessed by the physician and resident #001 was removed from the facility by a specific authority.

Director of Care (DOC) #101 provided the Inspector with camera footage. The footage was reviewed and showed a specific activity.

During an interview on a specific date, Director of Care #101 acknowledged that there had been a specific incident involving resident #001 and resident#002. DOC #101 also stated that resident #001 had a specific history.

The licensee has failed to ensure that resident #002 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 14th day of November, 2019

[redacted]

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

Original report signed by the inspector.