Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 18, 2023
Inspection Number: 2023-1034-0006
Inspection Type: Complaint Critical Incident
Licensee: Copper Terrace Limited
Long Term Care Home and City: Copper Terrace, Chatham

Lead Inspector	**Inspector Digital Signature**
Cassandra Taylor (725)	Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2023.09.29 14:19:10 -04'00'

Additional Inspector(s)
Jennifer Bertolin (740915)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6-8, 11-14, 2023
The inspection occurred offsite on the following date(s): September 14, 2023

The following intake(s) were inspected:

- Intake: #00092001 - Complainant relating to resident care and services, falls prevention and management and skin and wound care.
- Intake: #00095509 - Complainant relating to maintenance
- Intake: #00086663 - Critical Incident (CI) #1115-000013-23 relating to falls prevention and management
- Intake: #00087373 - CI #1115-000016-23 relating to falls prevention and management
- Intake: #00087590 - CI #1115-000017-23 relating to an unexpected death
- Intake: #00093995 - CI #1115-000028-23 relating to falls prevention

The following intakes were completed in this inspection: Intake #00090383, CI #1115-000022-23, and Intake # 00090868, CI #1115-000024-23 were related to falls.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 1.

The licensee failed to ensure the plan of care for a resident was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's customary routines.

Rationale and Summary
A complaint was submitted to the home requesting an item a resident used as part of their customary routine and at this time was not part of the residents plan of care relating to customary routines. The item took 15 days to install.

During an interview with both Assistant Directors of Care and Services (ADOCS) they indicated the expectation would be to complete any requests as soon as possible.

Sources: Resident records, complaints, work order and staff interviews with the ADOCS.
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WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure weekly skin and wound assessments were completed on a resident who was exhibiting altered skin integrity.

Rationale and Summary
A resident was noted to have an area of altered skin integrity, a treatment was ordered. No skin and wound assessment was completed on initial discovery.

Assessments were not completed weekly for the duration of the altered skin integrity.

During an interview with a registered staff member, they indicated that residents exhibiting altered skin integrity should receive a weekly skin and wound assessment. Executive Director (ED) confirmed the expectation was registered staff completed weekly skin and wound assessments as required.

Sources: Resident records and staff interviews with registered staff and ED.
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WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee failed to ensure that the response to complaints included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
Review of the home's complaints indicated follow-up had been completed however in the follow-up the Ministry's toll-free number for making complaints about homes and its hours of service and contact information for the patient ombudsman were not included.

During an interview with the ED they indicated that the contact information was not provided during the response.

Sources: Complaints and interview with the ED.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee failed to ensure that the response provided to the complainant included an explanation of what the licensee had done to resolve the complaint.

Rationale and Summary
A complaint was submitted to the home. A response letter was completed by an ADOCS, that did not include all the items listed within the complaint. Another complaint by the same complainant was submitted to the home on a later date, which included two of the same issues previously mentioned.

The home's policy indicated that a response to the complainant should have included information on how the complaint had been resolved.

The ED confirmed additional information to include should have been an explanation of what was done to resolve the complaint.

Sources: Complaints, the home's policy and interview with the ED.

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