Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
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Original Public Report

Report Issue Date: June 4, 2024	
Inspection Number: 2024-1034-0003	
Inspection Type: Critical Incident	
Licensee: Copper Terrace Limited	
Long Term Care Home and City: Copper Terrace, Chatham	
Lead Inspector Stacey Sullo (000750)	**Inspector Digital Signature**
Additional Inspector(s) Clare Hoevenaars (000834)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 30, 2024

The following intake(s) were inspected:

- Intake: #00112112 - Fall of resident.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Introduction
The licensee has failed to ensure that the resident's plan of care included all fall prevention interventions used by staff.

Rationale and Summary
The resident's plan of care indicated that there were fall prevention interventions in place. During an observation of the resident, the inspector noted the resident was sitting, however the fall intervention listed in the plan of care was not secured and attached to the resident.

During an interview with staff, they acknowledged and confirmed that the resident should have had their fall prevention intervention in place and secured to the resident at all times.

During an observation of the resident's room the inspector observed a fall prevention intervention in place, however that intervention was not listed on the

resident's plan of care.

The risk to the resident was low as the care plan was not up to date with all the current fall interventions used by staff.

Sources
Resident's care plan, observations of resident and their bedroom, interviews with staff.

[000834]