Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
October 19, 2010	2010-190-1115-18Oct102939	L-01449 Mandatory Report

Licensee/Titulaire

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(s)

Sandra Fysh #190

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection related to a Mandatory Report.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care, Registered Nurses.

During the course of the inspection, the inspector: conducted a record review, and reviewed the homes policies and procedures related to medications and emergency drug box.

The following Inspection Protocols were used in part or in whole during this inspection:
Critical Incident Response
Medication

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg.79/10,s.107(4)(4)(i)(ii) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Analysis and follow-up action, including, (i) the immediate actions that have been taken to prevent recurrence and (ii) the long-term actions planned to correct the situation and prevent recurrence.

Findings:

Following a critical incident involving a medication error for one resident, the licensee has failed to:

1. Complete a written report to the Director that includes analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence of this error.
2. Complete a written report to the Director that includes the long-term actions planned to correct the situation and prevent recurrence.

Inspector ID #:	190

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 with the reporting requirements for critical incidents including analysis and follow-up action(s) that have been taken to prevent recurrence. This plan is to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg.79/10,s.24(9)(a) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when, the resident's care needs change,

Findings:

- Review of the clinical record confirmed that one resident was not reassessed in response their changing condition.

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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 with assessment and re-assessment criteria, including review and revision of the plan of care when the resident's care needs change, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Stysh Nov 24/10
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).