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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2018	2018_536537_0019	015276-18, 016343-18, 018409-18, 018742-18, 018750-18	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

NANCY SINCLAIR (537), 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): July 26, 27 and 30, 2018

The following intakes were completed within this inspection:

Regarding staffing at the home:
Log #018742-18/IL-58330-LO
Log #018750-18/IL-58338-LO
Log #016343-18/IL-57754-LO
Log #015276-18/IL-57573-LO
Log #018408-18/IL-58236-LO

The following intakes were inspected at the same time as this complaint inspection and can be found in a separate report(s):

Follow up Inspection #2018_536537_0021
Log #012984-18/CO #001
Log #012987-18/CO #002
Critical Incident inspection #2018-536537_0020
Log #014413-18

During the course of the inspection, the inspector(s) spoke with the Vice President of Operations (VP Operations), Administrator, Director of Clinical Services, Assistant Director of Care (ADOC), Maintenance Supervisor, one Registered Nurse (RN), two Registered Practical Nurses (RPN), three Personal Support Workers (PSW), one Housekeeping staff, families and residents

The inspector(s) also observed residents and the care provided to them, meal service, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, staffing plans and evaluation of the staffing plan.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Sufficient Staffing

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

2 WN(s)
2 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	Legendé 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 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.

On July 26, 2018, the Administrator #100 provided a copy of the home's Personal Support Workers (PSW) staffing plan. The plan indicated the following complement of PSW staff:

Evenings:
2 North – 4 PSW
3 North – 3 PSW
2 East – 2 PSW and 1- four hour shift
3 East - 2 PSW and 1- four hour shift

The Administrator #100 also provided a copy of the home's Sufficient Staff Plan that stated the following: "All staff are to be replaced using the call-in procedures as per

collective agreement. First offer all staff in regular time, then offer the half shift the full shift at regular time. If no one accepts, then go into overtime as per collective agreement." The plan also included specific instructions for the Evening Shift when the home was short PSW staff.

The Vice President of Operations #101 shared that the corporation did contract with an agency for staffing requirements, but that this home did not utilize agency staff as part of their staffing plan.

a) A Complaint log submitted to the Ministry of Health and Long Term Care by a staff member at the home, indicated concerns of not being able to provide all required care to the residents of the home due to working short of staff from the expected staffing complement. The complainant provided specific dates and what staff were not present for the shifts as per the staffing plan.

Staff member #111 indicated that they completed the required care on their unit and then floated to a different unit to help. Staff member #111 indicated that at the end of the shift, scheduled baths on the unit had not been completed, and several residents remained up at end of shift as the staff were unable to complete care due to not being at the required staffing complement.

Staff member #111 stated that there was a process in place within the home for the replacement of shifts when staff were not able to come to their shifts as scheduled, but that despite this, the staff often did not work with a full complement of staff.

b) A Complaint log submitted to the Ministry of Health and Long Term Care by a family member of resident #003, indicated concerns regarding pending layoffs of staff at the home when their family member was already missing care. The family member of resident #003 indicated that their family was missing scheduled baths due to staffing shortages already without any staff layoffs.

The written plan of care for resident #003 included a focus of bathing and an intervention of a scheduled bath on a specific date and shift. Review of the clinical record in the Tasks tab of Point Click Care (PCC) indicated that on the specified day and shift, the scheduled bath was recorded as Not Applicable. Registered Practical Nurse (RPN) #105 stated they worked the shift and that PSW staff present as per the staffing schedule, and that a second RPN should have been scheduled and was not available for the shift. RPN #105 stated that resident #003 and all other residents scheduled for a bath on the shift

did not receive their baths due to being short staffed.

c) Two separate Complaint logs submitted to the Ministry of Health and Long Term Care by two different family members of resident #004 indicated concerns regarding pending layoffs of staff at the home when their family member was already missing care. Both family members of resident #004 indicated that their family was missing scheduled baths due to staffing shortages already without any staff layoffs.

The written plan of care for resident #004 included a focus of bathing and an intervention of a scheduled bath on a specific date and shift. Review of the clinical record in the Tasks tab of Point Click Care (PCC) indicated that on the specific date and shift, the scheduled bath was recorded as Not Applicable. PSW #104 stated they worked the shift and they were short staffed and the scheduled bath for resident #004 was not completed as scheduled.

On Jul 27, 2018 at 1007 hours, Administrator #100 stated they were aware that on specific dates and shifts, the shift did not work at the desired complement of staff, and that baths were missed as a result. Administrator #100 stated that attempts to fill shifts were implemented utilizing the home's call in process and then by redistributing the available staff as per the home's staffing plan when working short, but were unsuccessful and as a result, residents did receive hygiene care but did not receive tub baths as scheduled. Administrator #100 also shared an internal process for ensuring baths were rescheduled if missed, however, due to being unable to fill regular shifts, this process also was not able to be followed.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with the assessed care and safety needs, specifically tub baths, for residents #003 and 004. [s. 31. (3)]

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 staffing plan provides 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, to be implemented voluntarily.

WN #2: 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) Resident #004 shared with Inspector #537 that they had a specific schedule for bathing. Resident #004 shared that they did not receive their most recent scheduled bath. Review of the Point Click Care (PCC) Bathing Task documentation on the specified date and shift, noted the response to the question of Bath Given and specify type was documented as Not Applicable. The next documentation for this task was for a tub bath on the next specified day as per the care plan. There was no documented evidence of the scheduled bath noted as Not Applicable having been rescheduled and provided to resident #004.

On July 26, 2018 at 1340 hours, Personal Support Worker (PSW) #104 stated that they worked the specified shift. PSW #104 stated that they did not have a short shift PSW on either shift as per the expected staffing complement, and as a result, only one resident of

four was bathed on one shift, and that no scheduled baths were completed on the second scheduled shift and specifically that resident #003 did not get their bath as scheduled. PSW #104 shared that attempts were to be made to complete all care as scheduled despite staffing, and if baths were missed, the registered staff would be notified, and PSW #104 had posted an alert on PCC to notify that the bathing had not been completed. PSW #104 shared that the next shifts would attempt to complete the bathing, or if this was not able to be completed, then management would review the alerts and schedule an extra staff to come in and complete the missed baths before the next scheduled bath. PSW #104 shared that to the best of their knowledge, the residents scheduled baths noted as Not Applicable had not had their missed baths rescheduled and completed.

b) Review of the written plan of care for resident #003 included a bathing focus with a specific schedule for bathing. Review of the Point Click Care (PCC) Bathing Task documentation on the specified shift, noted the response to the question of Bath Given and specify type was documented as Not Applicable. The next documentation for this task was for a tub bath on the next specified day as per the care plan. There was no documented evidence of the scheduled bath documented as Not Applicable having been rescheduled and provided to resident #003.

On July 26, 2018 at 1430 hours, Registered Practical Nurse (RPN) #105 stated they worked the specified shifts. RPN #105 stated that on the specified shift, the floor was short two Personal Support Workers and the short shift from another home area was not able to float to the floor, as per the expected staffing complement. From memory and from reviewing the documentation in PCC, RPN #105 shared the scheduled bath for resident #003 was not completed on the shift. RPN #105 shared that to the best of their knowledge and from review of documentation, resident #003's scheduled bath documented as Not Applicable had not been rescheduled and completed.

On July 27, 2018 at 0910 hours, Administrator #100 stated they were aware that on the identified dates and shifts, the home was not staffed at the expected complement. Administrator #100 shared that the home's processes for covering shifts was implemented and followed, but that despite best efforts, staff were not available to come to work. Administrator #100 shared that they were aware that as a result of the staffing issues, residents did not receive scheduled baths. Administrator #100 shared that the expectation regarding missed baths would be that every effort be made for the bath to be completed as scheduled. If this was not achievable, the next shift should attempt to complete the missed care but that the expected staffing complement would be covered

first. Administrator #100 shared that if they become aware from staff notification that bathing had been missed, an assessment would be completed and if required, an extra staff would be booked to work to specifically complete the missed baths. Administrator #100 shared that the missed baths from the identified dates and shifts were not rescheduled and completed.

The licensee has failed to ensure that resident #003 and #004 were bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (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 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, to be implemented voluntarily.

Issued on this 27th day of August, 2018

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

Original report signed by the inspector.