**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 2, 2018 | 2018_607523_0026 | 019856-18, 021336-18, 024742-18, 026543-18, 026805-18 | 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**

ALI NASSER (523), TERRI DALY (115)

## 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): October 9, 10, 11, 12, 15, 16, 17 and 18, 2018.**

**The following intakes were completed within this inspection:**

**Complaint Log #021336-18 / IL-59039-LO related to staffing shortages and resident’s care concerns.**
**Complaint Log #024742-18 / IL-59752-LO related to staffing shortages and resident’s care concerns.**
**Complaint Log #026805 related to staff refusing to provide care to residents.**
**Complaint Log #026543-18 / IL-60482-LO related to staffing shortages and resident’s care concerns.**
**Complaint log #019856-18 / IL-58601-LO related to staffing shortages and resident’s care concerns.**
**Complaint Log #026909-18 / IL-60637-LO related to nursing coverage and medication administration.**
**Complaint Log #027030-18 / IL-60681-LO related to nursing coverage.**
**Complaint Log #027714-18 related to staffing shortages impacting resident’s care.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Dietary Services Manager, Environmental Services Manager, 11 Personal Support Workers (PSWs), eight Registered staff members, two Laundry aides, one restorative aide, 2 Dietary Aides, housekeeping staff member, scheduler, five family members and 17 residents.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Dignity, Choice and Privacy**
**Dining Observation**
**Medication**
**Personal Support Services**
**Skin and Wound Care**
**Sufficient Staffing**

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

**8 WN(s)**
**5 VPC(s)**
**3 CO(s)**
**2 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).**

**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.

Multiple complaints received through the Ministry of Health and Long-Term Care infoline related to recent cuts and changes to the staffing plan and staffing shortage impacting resident's care.

A) In an interview Administrator confirmed that PSW and nursing hours were cut as of a certain date. They said the decision to change the staffing plan was based on funding cuts and budget.

Administrator said that they were hearing from staff that they were not getting a lot of the resident's care tasks done.
Administrator said that since the date the cuts were effective they did not complete any audits to know if tasks related to bed making, repositioning, transferring, toileting and releasing and reapplying of restraints and/or PASD, were being completed as required.

In an interview DOC said that they were not involved in the decision making involving the cuts made, they were given the numbers of PSWs and were asked to create a staffing plan based on that.
DOC said that the residents' care needs have been impacted by staffing for some time now and despite them advocating to maintain previous staffing levels the decision was made to go ahead with the changes based on budget needs.

In an interview ADOC said that they worked with the DOC to develop the new staffing plan, they adopted and implemented the 2016 staffing model.
The ADOC said that prior to developing the new staffing plan they did not run or see any reports about resident's care or tasks being completed. They said that the current staffing plan did not meet the resident's care needs.

B) A review of the PSW schedules showed that the home worked short on PSWs as follows:
July 1-31, 2018, 27 out of 31 days the home had worked with unfilled shifts for a part of a shift and up to multiple shifts for a total of 82 shifts.
August 1-31, 2018, 28 out of 31 days the home had worked with unfilled shifts for a part of a shift and up to multiple shifts for a total of 89 shifts.
September 1-30, 2018, 28 out of 30 days the home had worked with unfilled shifts for a part of a shift and up to multiple shifts for a total of 110 shifts.
October 1-14, 2018, 9 out of 14 days the home had worked with unfilled shifts for a part of shift and up to multiple shifts for a total of 19 shifts.

In an interview ADOC said that they were aware of the challenges with staffing and inability to fill up shifts.

C) A complaint was received on certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to staffing concerns affecting the dining and snack services.

Observations by inspectors through out the inspection over the resident home care areas

showed that meal service was not delivered on time, identified residents had to wait for around an hour to receive their meal or the assistance they required during meal time.

During interviews multiple identified staff members told inspectors they had difficulties providing all the required care for the residents and ensure that residents were in the dining room on time, staff said that they could not make it to the dining room on time to serve meals to residents and to assist residents with meal service. (115)

D) A complaint was received on a certain date by the Ministry of Health and Long Term Care infoline related to care and services provided in the home including a specific resident not receiving scheduled baths.

A review of clinical records for five residents showed Point of Care (POC) reports for two of the five residents had documentation of “not applicable” for scheduled baths or showers for a specific period of time.

In an interview the Assistant Director of Care said that if the bath was documented as not applicable that it would mean that the bath was not done. They indicated that staff are to alert management when baths were not completed so that follow up can be conducted. (115)

E) A complaint was received on a certain date by the Ministry of Health and Long Term Care infoline related to care and services provided in the home related to staffing shortages including a specifc resident's bed was always a mess and not being made and concerns with the accessibility and response time to the call bell.

In an interview the resident said that the staff do not make their bed, their family make their bed when they visit and sometimes they would go to bed without it being made. The resident said they like their bed to be made and their room to be clean especially they they have company. The resident said that they could access the call bell but they had to wait an hour in the washroom for someone to come and help.

In an interview the ADOC said that with all the work load concerns the bed making priority fell down, they were aware that staff were not able to complete the bed making tasks to the residents. ADOC said that the expectation was for the bed to be made for residents, ADOC had no process in place to determine if beds were made at the end of the day shift.
In an interview the Administrator said that they were seeing struggles in completing

resident’s care tasks and then making a bed may become a secondary task to others. They were aware that staff were not able to make all the beds and were aware that staff were given direction not to make the resident’s beds and focus on other tasks.
The Administrator said that the expectation was that resident’s beds be made. Administrator had no audit to show how many beds were not being made on a daily basis since the staffing changes took place.

On a specific date during the inspection inspector #523 requested a resident-staff communication and response system Activity Report. The Administrator informed inspector that the computer that tracked and registered the resident-staff communication and response system data had been turned off since February 4, 2018. The system was turned on when inspector asked for the Activity Report.

F) A complaint was received on a certain date by the Ministry of Health and Long Term Care info line related to care and services provided in the home including a specific resident not receiving the required assistance in transferring and toileting.

On a certain date the complainant said in an interview that the home was short staffed and this was impacting the care delivered to their resident. Complainant said that the staff were not toileting the resident after their meals, the staff were not responding to the resident on time, as a result the resident was having a bowel movement while in bed or wheel chair and sitting in their bowel movements. They do not have enough staff during meal time, the resident could have had a cold breakfast today if it wasn’t for them around and helping.

Observation on a certain date showed the resident was still in the dining room with their family member, the family member was assisting in feeding the resident. A RN said that there were still 10 residents to be served breakfast.
The RN said that the resident was incontinent and required toileting before and after meals.
A specific PSW said that the resident was toileted today before breakfast and had not checked or changed them after breakfast or before lunch.
Observations showed that resident was not checked or toileted after breakfast and before lunch.

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.

The severity of this issue was determined to be a level 3 as there was an actual harm/risk to residents. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section that included:
Written Notification, Voluntary Plan of Correction from 2018_536537_0019.
Written Notification, Voluntary Plan of Correction from 2016_262523_0018 [s. 31. (3)]

2. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In an interview the Administrator said that there was no written record of the annual evaluation of the staffing plan or the review that was completed prior to implementing the recent staffing changes.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section that included:
Written Notification, Voluntary Plan of Correction from 2017_566669_0004
Written Notification, Voluntary Plan of Correction from 2016_262523_0018 [s. 31. (4)]

***Additional Required Actions:***

***CO # - 001, 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.***
***DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Multiple complaints received through the Ministry of Health and Long-Term Care infoline related to the home working without a Registered Nurse present at all times in the home which impacted the resident’s care including medication administration.

A) A review of the Registered Nursing staffing schedule showed the home with no RN as follows:
July 1-31 2018, 22 out of 31 days the home worked with no RN for part of a shift and up to multiple shifts.
August 1-31, 2018, 21 out of 31 days the home worked with no RN for part of a shift and up to multiple shifts.
September 1-30, 2018, 25 out of 30 days the home worked with no RN for part of a shift and up to multiple shifts.
October 1-14, 2018, 12 out of 14 days the home worked with no RN for part of a shift and up to multiple shifts.
Administrator #100 said that they were aware of the RN shortage and continue to work with external agency to recruit and hire RNs.

B) A review with ADOC of the late administration report for the medication administration record for a specific period of time showed multiple late administration of time specific medications. ADOC said that they were not aware of this report, they said that when they couldn’t find coverage one nurse would be covering two resident care areas and this would lead to late medication administrations.
ADOC said that it was the expectation to administer the medication within the hour as ordered by the physician.

The severity of this issue was determined to be a level 3 as there was an actual harm/risk to residents. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section that included:
Written Notification, Voluntary Plan of Correction from 2018_563670_0005.

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home fully respected and promoted the resident's right to have:
his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential, in accordance with the Act.

A complaint was received on certain date by the Ministry of Health and Long Term Care infoline. The complainant expressed concern that the home had recently implemented identification bracelets (ID) worn by the resident's that contained personal health information.

On a certain date inspector #739 observed a specific resident with a plastic ID bracelet on the back of the resident's wheelchair
The bracelet revealed the following information:
Resident's full name, the home name, the home's phone number, the resident's health care card number, the resident's date of birth and any allergies.

In an interview a specific PSW stated that they recalled seeing residents with these bracelets and the purpose of the bracelets was to let agency staff know who the resident's were.

In an interview the Administrator said that the ID bracelets were put in place for agency staff to identify residents, however the home had recognized that there was personal health information contained on the bracelets and had removed them all.
Inspectors indicated that they had seen them this week and the Administrator acknowledged that all the bracelets were supposed to have been removed and they would re-check again to ensure they had. [s. 3. (1) 11. iv.]

***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 home fully respected and promoted the resident's right to have:***
***his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential, in accordance with the Act, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to the outside of the home must be kept closed and locked.

Observations on a certain date showed that the door to the balcony on a certain resident care area was unlocked and unattended.

In an interview the Administrator confirmed that the door was unlocked and opened and that the expectation was for it to be locked and only activated by the keypad. Administrator requested that the nurse monitor the door and requested from the maintenance staff to work on the lock.

Observations on a later date showed that the keypad was active and the door was locked. [s. 9. (1) 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 all doors leading the outside of the home must be kept closed and locked, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin tears, was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A complaint was received on a specific date by the Ministry of Health and Long Term Care infoline. The complainant expressed concern that the home was not completing specific treatment for a specific resident.

Clinical record review for the resident showed that the weekly wound and skin assessment was not completed on a weekly basis.

The DOC said that the expectation was for staff to complete the weekly wound and skin assessments. [s. 50. (2) (b) (iv)]

2. A review of the clinical record showed that a specific resident had a certain area of altered skin integrity. A review of the individual assessments revealed that a weekly wound and skin assessment was not completed for this resident on a certain week.

The DOC said that the expectation was for the staff to complete the weekly wound and skin assessments. [s. 50. (2) (b) (iv)]

***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 a resident who exhibited altered skin integrity, including skin tears, was reassessed at least weekly by a member of the registered nursing staff if clinically indicated, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs that were stored in an area or a medication cart was secured and locked.

Observations on a certain date at the nursing station of a resident home area showed a treatment cart that was unlocked and unattended with over 25 prescription creams and ointments, a bottle of isopropyl Rubbing alcohol, 70%, a bottle of Dovidine solution and a box of Inadine adherent dressing.

A specific RPN confirmed that treatment cart was unlocked and unattended with the prescribed drugs in the cart. RPN said that the expectation was to have the treatment cart locked. [s. 129. (1) (a) (ii)]

***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 drugs that were stored in an area or a medication cart was secured and locked, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,**
**(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).**
**(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).**
**(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff

On a certain date inspector #735 observed a care cart in the long hall of a resident care area that had two prescription creams for specific residents.

During interviews specific PSWs indicated that they apply creams when needed while providing resident care. The PSWs said that they had not received education on topical cream application.

A review of the home's policy PSWs –Delegation of Medication Tasks Policy last reviewed February 2016, the home's policy states. "The management team will determine if a specific task may be taught and delegated to the PSWs, under the direction and supervision of the registered staff".
Under the procedure:
The registered staff or education co-ordinator will instruct/teach the PSW the task (i.e. application of creams/ointments). Once they feel the PSW has the knowledge and the skill to perform the task, they will have the designated PSW sign on the in-service/education sheet.
Once training is completed, the PSW will be responsible to report any concerns to the registered staff and ensure they feel competent in completing the task.
The PSW will sign for administering the treatment cream on the TAR.
The registered staff will be responsible to ensure continued supervision, monitoring and evaluation of the PSW's task. The registered staff will also evaluate the effectiveness of the treatment.

In an interview a specific RPN stated that the PSW staff apply prescription creams while providing care to residents.

The Administrator said in an interview that they were not aware that PSW staff were applying topicals, and that they were not aware that any education had been done in

relation to this. [s. 131. (4)]

***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 registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:***
***(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals***
***(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and***
***(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's resident-staff communication and response system allowed calls to be cancelled only at the point of activation.

Observations on a certain date during the inspection showed the resident communication system was activated, a telephone/intercom was on the nursing station, inspector #523 asked a specific RPN if they used the intercom to answer the call bell, RPN said that they used to be able to communicate with the resident from the intercom, but now they could just cancel the call bell.
Inspector #721 activated the resident-staff communication and response system from specific rooms on three different home areas, inspector #523 was able to deactivate the system from nursing stations.

DOC confirmed with inspectors #523 and #721 that the resident-staff communication and response system could be deactivated from the nursing station.
Administrator said that an external company would be coming in to work on the system.

Inspectors confirmed that the system would allow calls to be cancelled only at the point of activation. [s. 17. (1) (c)]

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**Issued on this 29th day of November, 2018**

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

**Original report signed by the inspector.**

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ALI NASSER (523), TERRI DALY (115) |
| **Inspection No. / No de l'inspection :** | 2018_607523_0026 |
| **Log No. / No de registre :** | 019856-18, 021336-18, 024742-18, 026543-18, 026805-18 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Nov 2, 2018 |
| **Licensee / Titulaire de permis :** | Copper Terrace Limited<br>284 Central Avenue, LONDON, ON, N6B-2C8 |
| **LTC Home / Foyer de SLD :** | Copper Terrace<br>91 Tecumseh Road, CHATHAM, ON, N7M-1B3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Nicole Ross |

To Copper Terrace Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

**Order / Ordre :**

The licensee must be compliant with s. 31(3) of O. Reg 79/10.
Specifically, the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs and shall ensure the following:

a) Develop, document and implement a process in the home to identify the assessed care and safety needs of the residents in each home area; and a corrective action plan to ensure that all residents receive their assessed care and safety needs including but not limited to: bathing twice per week by the method of their choice, transferring and positioning, releasing and reapplying restraints and/or PASDs, toileting, proper, timely and safe service and assistance for meals and responding to resident-staff communication and response system. Records for these audits are to be maintained.

b) Ensure that all nursing and personal support staff are educated on the home's documentation policy including documentation in Point of Care and Point Click Care.

**Grounds / Motifs :**

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.

Multiple complaints received through the Ministry of Health and Long-Term Care infoline related to recent cuts and changes to the staffing plan and staffing shortage impacting resident's care.

A) In an interview Administrator confirmed that PSW and nursing hours were cut as of a certain date. They said the decision to change the staffing plan was based on funding cuts and budget.
Administrator said that they were hearing from staff that they were not getting a lot of the resident's care tasks done.
Administrator said that since the date the cuts were effective they did not complete any audits to know if tasks related to bed making, repositioning, transferring, toileting and releasing and reapplying of restraints and/or PASD, were being completed as required.

In an interview DOC said that they were not involved in the decision making involving the cuts made, they were given the numbers of PSWs and were asked to create a staffing plan based on that.
DOC said that the residents' care needs have been impacted by staffing for some time now and despite them advocating to maintain previous staffing levels the decision was made to go ahead with the changes based on budget needs.

In an interview ADOC said that they worked with the DOC to develop the new staffing plan, they adopted and implemented the 2016 staffing model.
The ADOC said that prior to developing the new staffing plan they did not run or see any reports about resident's care or tasks being completed. They said that the current staffing plan did not meet the resident's care needs.

B) A review of the PSW schedules showed that the home worked short on PSWs as follows:
July 1-31, 2018, 27 out of 31 days the home had worked with unfilled shifts for a part of a shift and up to multiple shifts for a total of 82 shifts.
August 1-31, 2018, 28 out of 31 days the home had worked with unfilled shifts for a part of a shift and up to multiple shifts for a total of 89 shifts.

September 1-30, 2018, 28 out of 30 days the home had worked with unfilled shifts for a part of a shift and up to multiple shifts for a total of 110 shifts. October 1-14, 2018, 9 out of 14 days the home had worked with unfilled shifts for a part of shift and up to multiple shifts for a total of 19 shifts.

In an interview ADOC said that they were aware of the challenges with staffing and inability to fill up shifts.

C) A complaint was received on certain date by the Ministry of Health and Long-Term Care (MOHLTC)  infoline related to staffing concerns affecting the dining and snack services.

Observations by inspectors through out the inspection over the resident home care areas  showed that meal service was not delivered on time, identified residents had to wait for around an hour to receive their meal or the assistance they required during meal time.

During interviews multiple identified staff members told inspectors they had difficulties providing all the required care for the residents and ensure that residents were in the dining room on time, staff said that they could not make it to the dining room on time to serve meals to residents and to assist residents with meal service. (115)

D) A complaint was received on a certain date by the Ministry of Health and Long Term Care infoline related to care and services provided in the home including a specific resident not receiving scheduled baths.

A review of clinical records for five residents showed Point of Care (POC) reports for two of the five residents had documentation of “not applicable” for scheduled baths or showers for a specific period of time.

In an interview the Assistant Director of Care said that if the bath was documented as not applicable that it would mean that the bath was not done. They indicated that staff are to alert management when baths were not completed so that follow up can be conducted. (115)

E) A complaint was received on a certain date by the Ministry of Health and Long

Term Care infoline related to care and services provided in the home related to staffing shortages including a specifc resident’s bed was always a mess and not being made and concerns with the accessibility and response time to the call bell.

In an interview  the resident  said  that the staff do not make their bed, their family make their bed when they visit and sometimes they would go to bed without it being made. The resident said they like their bed to be made and their room to be clean especially they they have company. The resident said that they could access the call bell but they had to wait an hour in the washroom for someone to come and help.

In an interview the ADOC said that with all the work load concerns the bed making priority fell down, they were aware that staff were not able to complete the bed making tasks to the residents. ADOC said that the expectation was for the bed to be made for residents, ADOC had no process in place to determine if beds were made at the end of the day shift.
In an interview the Administrator said that they were seeing struggles in completing resident’s care tasks and then making a bed may become a secondary task to others. They were aware that staff were not able to make all the beds and were aware that staff were given direction not to make the resident’s beds and focus on other tasks.
The Administrator said that the expectation was that resident’s beds be made. Administrator had no audit to show how many beds were not being made on a daily basis since the staffing changes took place.

On a specific date during the inspection inspector #523 requested a resident-staff communication and response system Activity Report. The Administrator informed inspector that the computer that tracked and registered the resident-staff communication and response system data had been turned off since February 4, 2018. The system was turned on when inspector asked for the Activity Report.

F) A complaint was received on a certain date by the Ministry of Health and Long Term Care info line related to care and services provided in the home including a specific resident not receiving the required assistance in transferring and toileting.

On a certain date the complainant said in an interview that the home was short staffed and this was impacting the care delivered to their resident. Complainant said that the staff were not toileting the resident after their meals, the staff were not responding to the resident on time, as a result the resident was having a bowel movement while in bed or wheel chair and sitting in their bowel movements. They do not have enough staff during meal time, the resident could have had a cold breakfast today if it wasn't for them around and helping.

Observation on a certain date showed the resident was still in the dining room with their family member, the family member was assisting in feeding the resident. A RN said that there were still 10 residents to be served breakfast. The RN said that the resident was incontinent and required toileting before and after meals.
A specific PSW said that the resident was toileted today before breakfast and had not checked or changed them after breakfast or before lunch.
Observations showed that resident was not checked or toileted after breakfast and before lunch.

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.

The severity of this issue was determined to be a level 3 as there was an actual harm/risk to residents. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section that included:
Written Notification, Voluntary Plan of Correction from 2018_536537_0019.
Written Notification, Voluntary Plan of Correction from 2016_262523_0018 [s. 31. (3)] (115)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Dec 31, 2018

**Order # / Ordre no :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be compliant with s. 8. (3) of the LTCHA
Specifically, the licensee shall ensure the following:

a) Develop, document and implement a process in the home to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

**Grounds / Motifs :**

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Multiple complaints received through the Ministry of Health and Long-Term Care infoline related to the home working without a Registered Nurse present at all times in the home which impacted the resident's care including medication administration.

A) A review of the Registered Nursing staffing schedule showed the home with no RN as follows:
July 1-31 2018, 22 out of 31 days the home worked with no RN for part of a shift and up to multiple shifts.
August 1-31, 2018, 21 out of 31 days the home worked with no RN for part of a shift and up to multiple shifts.
September 1-30, 2018, 25 out of 30 days the home worked with no RN for part

of a shift and up to multiple shifts.
October 1-14, 2018, 12 out of 14 days the home worked with no RN for part of a shift and up to multiple shifts.
Administrator #100 said that they were aware of the RN shortage and continue to work with external agency to recruit and hire RNs.

B) A review with ADOC of the late administration report for the medication administration record for a specific period of time showed multiple late administration of time specific medications. ADOC said that they were not aware of this report, they said that when they couldn't find coverage one nurse would be covering two resident care areas and this would lead to late medication administrations.
ADOC said that it was the expectation to administer the medication within the hour as ordered by the physician.

The severity of this issue was determined to be a level 3 as there was an actual harm/risk to residents. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section that included:
Written Notification, Voluntary Plan of Correction from 2018_563670_0005.
(523)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2018

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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**Order # / Ordre no :** 003

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

**Order / Ordre :**

The licensee must be compliant with s. 31(4) of O. Reg 79/10.
Specifically, the licensee shall ensure the following:

a) A written record will be kept relating to each staffing plan evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In an interview the Administrator said that there was no written record of the annual evaluation of the staffing plan or the review that was completed prior to implementing the recent staffing changes.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section that included:
Written Notification, Voluntary Plan of Correction from 2017_566669_0004
Written Notification, Voluntary Plan of Correction from 2016_262523_0018 [s. 31. (4)] (523)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Nov 30, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 2nd day of November, 2018**

**Signature of Inspector / Signature de l’inspecteur :**

**Name of Inspector / Nom de l’inspecteur :** Ali Nasser

**Service Area Office / Bureau régional de services :** London Service Area Office