Ontario

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
Aug 14, 2019	2019_526645_0009	029708-18, 003983-19, 005412-19, 008406-19	Complaint

Licensee/Titulaire de permis

Copernicus Lodge
66 Roncesvalles Avenue TORONTO ON M6R 3A7

Long-Term Care Home/Foyer de soins de longue durée

Copernicus Lodge
66 Roncesvalles Avenue TORONTO ON M6R 3A7

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

DEREGE GEDA (645), ADAM DICKEY (643)

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 25, 26, 29, 30, 31 and August 1, 2019.

The following critical incidents with log# 003983-19 related to residents' bill of rights, log# 008406-19 related to medication administration, log# 029708-18 related to skin and wound management, and Log# 005412-19 related to prevention of abuse and neglect, were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapy Assistant (PTA), Personal Support Workers, (PSWs), and Residents.

During the course of the inspection, the inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

The licensee has failed to ensure that the residents' 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 that Act was fully respected and promoted.

A written complaint was submitted to the MOLTC from resident #011's family member which indicated that they had complained to staff about a co-resident's responsive behaviours disturbing resident #011. The letter further indicated that RN #122 showed them a handwritten note with the co-resident's name and the name of a specific medication.

In an interview, resident #011's family member indicated that they had spoken to the staff on the unit about a co-resident who was demonstrating responsive behaviours, and RN #122 became argumentative with them about the issue. Resident #011's family member indicated RN #122 then approached them in resident #011's washroom and placed a piece of paper on the counter with the resident's name that they were referring to and a medication written on it. They told the family member that an identified treatment had been administered to the co-resident to manage the behaviour and staff were doing all

they could.

Review of the home's investigation into the above incident showed a handwritten note was retained by resident #011's family member and given to the DON and ADON. The handwritten note showed resident #012's last name, and the identified treatment name.

Review of resident #012's progress notes showed that, the identified treatment was administered as the resident was exhibiting responsive behaviours. RN #122 documented resident #011's family member complained to them that resident #012 had been exhibiting the behaviours, disturbing resident #011, and that the treatment was provided but took time to take effect.

In an interview, RN #122 indicated that they felt that resident #011's family member did not trust that the staff in the home were doing anything to manage resident #012's responsive behaviours. RN #122 indicated they provided the handwritten note to prove that something was being done to manage the behaviours. RN #122 acknowledged that it was a breach of privacy to give resident #011's family member Personal Health Information (PHI) about resident #012.

In an interview, the ADON indicated that resident #011's family member had reported to the management that a privacy breach had taken place. The ADON indicated that the matter was investigated by the home and determined that resident #012's PHI was not kept confidential as RN #122 had no right to communicate about resident #012 with resident #011's family [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 residents' 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 that Act was fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1.The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of resident #011's plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

The Ministry of Long-Term Care (MOLTC) received complaint from resident#011's family member concerning medication administration. The complainant indicated resident #011 had been administered an identified type of treatment which was not required.

In an interview, resident #011's family member indicated that the resident was administered the treatment three days in a row with good treatment outcome. The family

member indicated that the following day after the last treatment, it was reported to them by the resident's private sitter and PSW #121 that resident #011 had the expected outcome and the treatment had been effective.

Record review of resident #011's point of care (POC) documentation did not indicate if the treatment outcome was documented. Record review of the clinical records indicated that the resident is to receive the treatments only up to the required outcome is obtained. Review of resident #011's clinical record indicated the treatment was provided to the resident even after the outcome was achieved.

In an interview, PSW #121 indicated that they recalled resident #011's private sitter had reported to them that the resident had the expected treatment outcome. PSW #121 indicated that they were not the assigned PSW for resident #011 and had reported the treatment outcome to primary PSW #125, in order to document the outcome on POC. In an interview, PSW #125 did not recall if PSW #121 reported to them, nor did they recall if they documented or reported to registered staff that resident #011 had the targeted treatment outcome.

In an interview, the ADON indicated that the process in the home was for registered staff to review the clinical alerts in pointclickcare (PCC) for residents who require the identified treatment and provide treatments as per protocol. They also indicated that PSWs were expected to document the treatment outcome to alert the registered staff.
The ADON acknowledged that PSWs #121 and #125 did not document or report to registered staff that resident #011 had the required treatment outcome and confirmed that the staff had not collaborated in the implementation of resident #011's plan of care.
[s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by MOLTC from a family member of resident #001. The complaint stated that the staff members at the home do not provide an identified type of care for resident #001 regularly.

Record review of the resident's plan of care indicated that the resident needed the care every two hours to prevent injury.

Review of a video surveillance footage revealed that staff members were not providing the care for resident #001 every two hours on an identified date. Further review of the video footage indicated the following on different occasions:
- On first occasion: resident #001 was observed lying in bed. The video footage indicated that the resident was in the same position up to the next day. Staff were observed going in and out of the room, but no care provision was performed.

- Second occasion: resident #001 was observed in high fowler (45degree) position for breakfast. The video footage revealed that the resident was in the same position for several hours. Staff were observed changing the level of the head of the bed and but no specified care provision was performed.

- Third occasion: resident #001 was observed in high fowler (45degree) position for dinner. The video footage revealed that the resident was in the same position untill the next morning. Staff were observed lowering the head of the bed.

- Forth occasion: resident #001 was observed in high fowler position and remained in the same position up to the next day. Staff were observed elevating and lowering the head of resident #001's bed. The video footage indicated that staff were not providing the identified care through out the night. Similarly, on the fifth occasion, staff were observed performing other type of tasks but the identified care was not provided.

Inspector #645 observed resident #001 on three different occasions. On all the occasions, the resident was observed in the same position.

Interviews with PSW #118 and #119 were conducted on an identified date. During the interview, PSW #118 and #119 indicated that they provide the identified care for the resident randomly through out their shift but not every two hours.

Inspector #645 reviewed the video footage with the administrator and ADOC. After reviewing the video, the ADOC confirmed that staff were not providing the care every two hours as specified in the plan of care.

3. A complaint was received by MOLTC from a family member of resident#001. The complaint stated that the home does not provide an identified type of therapy for resident #001. The complainant stated that the resident was supposed to receive therapy three

times per week, but they don't think the home is providing the care.

Record review of the plan of care indicated that resident #001 required 20-30 minutes of the therapy three times per week.

Record review indicated that the home received the complaint and completed an investigation. The investigation notes indicated that the identified staff provided six minutes of the therapy session for resident #001 on an identified date. The note also indicated that the staff falsely documented on the therapy-tracking tool as if 20 minutes of the therapy was provided to the resident. Further review of the record indicated that the staff was disciplined, and a letter of education was provided to them.

Interview with the staff confirmed that they provided six minutes of therapy on the identified date and falsely documented on the tracking tool. They indicated that they regretted the incident. They reiterated that this incident was an isolated incident and not a true reflection of how they care for residents.

An interview with the ADOC confirmed that resident #001 received six minutes of the identified therapy. They indicated that the resident required a minimum of 20 minutes of the therapy three time per week. They reiterated that staff members are expected to provide care as specified in the plan of care and confirmed that resident #001 did not receive care as specified in the plan [s. 6. (7)]

4. The licensee has failed to ensure that staff members who provide direct care to resident #001, were kept aware of the contents of the plan of care.

A complaint was submitted to the MOLTC from a complainant, who is the family member of resident #001. The complainant stated that the staff members at the home do not provide an identified type of care for resident #001 regularly.

Record review of the resident's plan of care indicated that the resident needed the care every two hours to prevent altered skin injury.

Interviews with PSWs #118 and #119, indicated that they provide the care randomly through out their shift but not every two hours. They indicated that the resident plan of care/kardex directed staff members to provide the care regularly, but not every two hours. The two PSWs accessed the plan of care during the interview and confirmed that resident #001 needed the care every two hours. Both PSWs confirmed that they were

not aware that the resident needed the care every two hours.

Interview with the ADOC confirmed that the plan of care for resident #001 directed staff members to provide the identified care every two hours. They reiterated that it is the expectation of the home that staff members review residents' plan of care and update themselves with the content prior to commencing care. [s. 6. (8)]

5. The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

In an interview, resident #011's family member indicated that the resident had a change of medication on an identified date. Resident #011's family member indicated that they had expressed concern regarding the medication change. The family member indicated that the physician had intended to hold the medication for specific time duration and then reduced the dosage. The family member indicated that the resident was hospitalized during that time and returned to the home with the identified medication and had been receiving it since.

Review of resident #011's clinical records showed they had been receiving the medication since 2018. Review of resident #011's physician order form showed that a telephone order was received to hold the identified medication and to reassess. A subsequent telephone order was written on the same day to reduce the dosage of the medication and to weigh the resident.

In an interview, RN #120 indicated that staff were monitoring the resident in relation to the above change in medication dosage by weighing them regularly. RN #120 indicated that the process in the home was for staff to weigh the resident and check off that it had been completed in the computer and document the weights in the vitals tab in PCC.

Review of resident #011's clinical records for weight documentation showed staff had endorsed weight measurement was completed each day. Review of weight documentation in the vitals tab in PCC showed that a weight measurement had not been recorded on an identified date.
In an interview, RN #123 indicated that the process in the home was for staff to complete weight measurement and document the weight in the vitals tab in PCC. RN #123 acknowledged that they had endorsed that the weight was measured, however could not recall if the weight was documented.

In an interview, the ADON indicated that when a resident had an order written to be weighed at a specific frequency, an order would be entered into the resident's clinical records for registered staff to complete. The ADON indicated that staff were expected to complete the weight measurement and document the measurement in the resident's vitals tab in PCC. The ADON acknowledged that the weight measurement was not completed and documented for resident #011, as set out in the physician orders [s. 6. (9) 2.]

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 staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of residents' plan of care so that the different aspects of care were integrated and consistent with and complemented each other and all staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and to ensure that the care set out in the plan of care was provided to the residents as specified in the plan and care outcomes are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

A complaint was received via the MOLTC INFO-Line regarding alleged staff to resident abuse, indicating resident #016 was abused by a member of the multidisciplinary team.

Record review of the written complaint letter submitted to the home indicated that the complainant notified the home about the allegation of abuse. Further review of the home's records did not indicate if the allegation of abuse was investigated immediately.

An interview with the Administrator confirmed that the home did not investigate the allegation of abuse. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged incident of abuse of a resident, by the licensee or staff, was immediately reported to the Director.

A complaint was received via the MOLTC INFO-Line regarding alleged staff to resident abuse, indicating resident #016 was abused by a member of the multidisciplinary team.

Record review of the written complaint letter submitted to the home indicated that the complainant notified the home about the allegation of abuse. Further review of the records did not indicate if the MOLTC was notified about the alleged incident of abuse.

The complainant stated that a member of the multidisciplinary team verbally threatened the resident.

The Inspector reviewed the Long-Term Care Homes.net reporting website and was unable to locate a mandatory critical incident report submitted by the home, regarding the alleged incident of abuse.

Review of the written conversation between the Administrator and the resident indicated that the Administrator was aware of the alleged incident. A review of the home's complaints binder did not indicate if the home notified the MOLTC.

An interview with the Administrator confirmed that they received the alleged incident of abuse from resident #016's POA but did not report it to the MOLTC. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A complaint was received by MOLTC, from a family member of resident #001. The complaint stated that the staff members at the home do not provide an identified type of care for resident #001 regularly.

Record review of the current plan of care indicated that the resident needed the care every two hours to prevent skin breakdown. Further review of the clinical records indicated that there was no documentation available regarding the provision of care.

Interviews with RN #116 and RPN #117 confirmed that there was no documentation available regarding the care. They reiterated that the PSWs used to document on the Point of Care (POC) after they perform the care. RN #116 indicated that registered staff are expected to activate the POC documentation task for the PSWs to document the care and they were not sure what happened in this case.

Interview with the ADOC confirmed that there was no documentation available and indicated that under the skin care program, staff are expected to document the care on the POC. [s. 30. (2)]

Issued on this 23rd day of August, 2019

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

Original report signed by the inspector.