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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2020	2020_767643_0003	016485-19, 023709-19	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

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): January 17 and 20-24, 2020.

The following Complaint intakes were inspected during this inspection:
Log #016485-19 - related to nutrition and hydration, dining and snack service; and
Log #023709-19 - related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Manager of Dietary Services, Personal Support Workers (PSW), residents and family members.

During the course of the inspection the inspector conducted observations of staff and resident interactions and the provision of care, observations of dining and snack service, reviewed resident health records, hospital admission records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The inspector conducted observations of the dining service on an identified resident home area on an identified date, during a specified meal service. Observations by the inspector showed PSW #103 serving entrees to residents during a specified time period. Resident #023 was served a meal approximately six minutes prior to PSW #105 assisting them with feeding.

The inspector observed resident #021 seated with an entrée in front of them on the dining table and the resident was not initiating self-feeding. Resident #021 was observed to be sitting with their entrée in front of them for approximately 13 minutes before PSW #103 sat with them and assisted them with feeding.

The inspector observed resident #022 self-feeding with an entree on the dining table prior to PSW #105 sitting with the resident and providing encouragement and assistance with feeding.

The three above residents care plans were reviewed which indicated the following:
- Resident #021: eating ability impaired, required extensive assistance from staff;
- Resident #022: eating ability impaired, extensive assistance with feeding; and
- Resident #023: eating ability impaired, required total assistance from staff for feeding.

In an interview, PSW #103 indicated that they were aware that residents who required assistance with feeding should not be served a meal prior to someone being available to assist them. PSW #103 indicated that resident #023 was able to feed themselves at times, though required supervision and at times required physical assistance with feeding. PSW #103 indicated that resident #022 required total assistance with feeding as they would not initiate the meal unassisted. PSW #103 indicated that they were aware that resident #022 required assistance with feeding, however the resident would not often allow staff to assist them.

In an interview, RPN #104 indicated that they were aware residents who required assistance with feeding were not to be served a meal until someone was available to assist them. The RPN indicated that according to each resident’s plan of care, residents #021, #022 and #023 all required assistance with feeding. RPN #104 indicated that residents #021, #022 and #023 were all served meals before someone was available to

assist them.

In an interview, Manager of Dietary Services #119 indicated that it was the expectation of the home for PSW staff to wait to serve residents who require assistance with feeding until someone is available to assist them. Staff #119 indicated that the dietary staff would keep the food items in the steam table until the PSW staff requested to serve the residents requiring assistance. Staff #119 indicated that the residents requiring assistance should not be served until assistance is available to maintain food quality and temperature, as well as to reduce risk of choking for residents with dysphagia. The Manager of Dietary Services acknowledged that residents #021, #022 and #023 were served meals prior to someone being available to assist them and should not have been. [s. 73. (2) (b)]

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 no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.