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 prévue le Loi de 2007 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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2017;	2017_635600_0004 (A1)	000410-16, 008113-16, 029295-16	Critical Incident System

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Order compliance date changed to April 24, 2017.

Issued on this 13 day of April 2017 (A1)

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

Original report signed by the inspector.

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

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Apr 13, 2017;	2017_635600_0004 (A1)	000410-16, 008113-16, 029295-16	Critical Incident System

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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

GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 23, 24, 25, 26, 27, 30, 31 and February 1, 3, 2017.

During the course of the inspection, the critical incidents (CIs) log #029295-16, and #000410-16, for falls prevention and #008113-16, for responsive behaviour management were inspected.

During the course of the inspection, the inspector(s) spoke with the acting chief executive officer (ACEO), director of care (DOC), registered nurses (RNs), personal support workers (PSWs), and physiotherapist (PT).

During the course of the inspection, the inspectors conducted observations of the residents' area, observation of staff resident interaction, observation of care delivery processes including transfers, review of residents' files and the home's policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

2 WN(s)
0 VPC(s)
1 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours.

Review of critical incident system report (CIS) revealed that on an identified date resident #002 used his/ her assisting device to push resident #001 causing incident resulting transfer to hospital.

Review of resident #002's progress notes revealed a few incidents in which resident #002 used his/her device in altercation with co-residents in two identified months of 2015. Three of the above mentioned incidents involved resident #001.

Interviews with PSW #100, RN #101, PSW #102, and RN #104 revealed that staff on the floor were aware of resident #002's history of identified behaviour with his/her device. RN #104 stated that he/she was aware that resident #002 had used his/her device in altercation with resident #001.

Resident #002's written plan of care from a specified date indicated that he/she was identified at risk level indicating his/her behaviours will cause risk to staff and/or other residents. Staff were instructed to refer to the behavioural management care plan for specific behaviours, triggers and interventions.

Review of resident #002's behavioural management care plan from a specified date revealed that the identified behaviours were not identified at that time. The behavioural care plan was not revised until the day the incident with resident #001 occurred. Review of resident #002's behavioural management care plan from the specified date revealed that the above mentioned behaviours were identified. There were some interventions listed for resident #002's behaviours.

In an interview with the assistant director of care (ADOC) who is the lead for the behaviour management program in the home he/she stated that interventions should be developed when a resident exhibits new behaviours. The ADOC further stated that altercation with co-residents with his/her device was a new responsive behaviour for resident #002. The ADOC agreed that the strategies were not developed and implemented to respond to resident #002's newly identified responsive behaviour with his/her device. The licensee has failed to ensure that for resident #002 demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours.

The scope was identified to be isolated to one resident; severity was identified to be level three as resident #001 sustained change in his/her condition as a result of the responsive behaviour of resident #002. Resident #002 had a documented history of exhibiting the responsive behaviour with his/her device prior to the mentioned incident therefore a compliance order is warranted. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused change to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health condition.

Review of critical CIS revealed that on an identified date resident #002 used his/ her assisting device in altercation with resident #001 on the identified date causing an incident involving resident #001. The CIS report was first submitted to the Ministry of Health and Long-Term Care (MOHLTC) after eight days.

Review of progress notes for resident #001 revealed that on an identified date the home's physician was contacted and ordered a further assessment of the resident.

Two days after the progress notes revealed that the assessment results revealed a change in the resident condition . The resident was sent to hospital to be treated.

2. Review of CIS revealed that resident #004 had a few incidents on an identified date. The next day the staff noted resident #004 to have change in both extremities. The resident was sent to hospital for further assessment. A treatment had been provided and resident was sent back home. The CIS report was first submitted to the MOHLTC the following month.

Review of resident #004's written plan of care revealed that the resident was identified to be at risk and he/she had incident on identified date. The resident was sent to the hospital on following day, and confirmed that resident sustained change to both extremities.

Interview with registered practical nurse (RPN) #110 revealed when the resident had a significant change in his/her condition following the incident they notified the DOC immediately. [s. 107. (3)]

3. Review of CIS revealed on an identified date resident #003 was found by the staff on an identified area, complaining of discomfort in his/her part of body and had difficulty weight bearing. The resident was sent to the hospital for further assessment and treatment. The hospital confirmed the resident had a change in condition of his/her identified body part. The DOC had been informed. The CIS report was first submitted to the MOHLTC on later dates.

In an interview the DOC stated that he/she had thought the MOHLTC requirement for reporting had changed for an incident which requires a resident to be sent to hospital which results in a significant change in the resident's health condition. The DOC admitted that the requirement for reporting to the Director for this type of incident is no later than one business day after the occurrence of the incident. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health condition. [s. 107. (3)]

Issued on this 13 day of April 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : GORDANA KRSTEVSKA (600) - (A1)

Inspection No. / No de l'inspection : 2017_635600_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 000410-16, 008113-16, 029295-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Apr 13, 2017;(A1)

Licensee / Titulaire de permis :
COPERNICUS LODGE
66 RONCESVALLES AVENUE, TORONTO, ON, M6R-3A7

LTC Home / Foyer de SLD :
COPERNICUS LODGE
66 RONCESVALLES AVENUE, TORONTO, ON, M6R-3A7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Catherine Kowalenko

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To COPERNICUS LODGE, 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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

Upon receipt of this compliance order the licensee will:
i. Ensure that for resident #002 demonstrating responsive behaviours that strategies are developed and implemented to respond to these behaviours;
ii. Discuss with care staff to identify patterns of behaviours of resident #002 and interventions used to respond to his/her responsive behaviours; and
iii. Document and keep a record of discussion with care staff, materials presented, dates of discussion, and staff members in attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours.

Review of critical incident system report (CIS) revealed that on an identified date resident #002 used his/ her assisting device to push resident #001 causing incident resulting transfer to hospital.

Review of resident #002's progress notes revealed a few incidents in which resident #002 used his/her device in altercation with co-residents in two identified months of 2015. Three of the above mentioned incidents involved resident #001.

Interviews with PSW #100, RN #101, PSW #102, and RN #104 revealed that staff on the floor were aware of resident #002's history of identified behaviour with his/her device. RN #104 stated that he/she was aware that resident #002 had used his/her device in altercation with resident #001.

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In an interview with the assistant director of care (ADOC) who is the lead for the behaviour management program in the home he/she stated that interventions should be developed when a resident exhibits new behaviours. The ADOC further stated that altercation with co-residents with his/her device was a new responsive behaviour for resident #002. The ADOC agreed that the strategies were not developed and implemented to respond to resident #002's newly identified responsive behaviour with his/her device. The licensee has failed to ensure that for resident #002 demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours.

The scope was identified to be isolated to one resident; severity was identified to be level three as resident #001 sustained change in his/her condition as a result of the responsive behaviour of resident #002. Resident #002 had a documented history of exhibiting the responsive behaviour with his/her device prior to the mentioned incident therefore a compliance order is warranted. (643)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Apr 24, 2017(A1)

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 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 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

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13 day of April 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GORDANA KRSTEVSKA - (A1)

Service Area Office /
Bureau régional de services : Toronto