Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 9, 2018	2018_654618_0024	023375-18	Resident Quality Inspection

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

CECILIA FULTON (618), ADAM DICKEY (643), JUDITH HART (513), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 28, 29, 30, 31, September 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 2018.

The following complaint intake logs were inspected concurrently with this Resident Quality Inspection (RQI):
025594-17 - related to falls;
008300-18 - related to medication administration and infection prevention;
023266-17 - related to discharge practices;

001139-18 - related to housekeeping;
013376-18, 007335-18, 018309-17 - related to prevention of abuse and plan of care.

The following Critical Incident System (CIS) report intakes were inspected concurrently with this RQI:
022159-18, (CIS #2937-000020-18) and 013338-18 (CIS # 2937-000014-18) - related to falls.

The following follow up inspections were inspected concurrently with this RQI:
Intake #009176-18, related to abuse and neglect and resident charges;
Intake #019226-17, related to resident charges.

Inspector #727, Joanna White, attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Wound Care Nurse, Personal Support Worker (PSW), Registered Dietitian (RD), Food Services Supervisor (FSS), Manager of Dietary Services, Director of Dietary Services, Dietary Service Supervisor, Dietary Aide, Placement and Resident services coordinator, Physiotherapy Assistant, Housekeeper, Behavioural Support Lead (BSO), Family Council representatives, Residents' Council chair, Residents and Family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed dining service, observed medication administration, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_644507_0008	618
O.Reg 79/10 s. 245.	CO #001	2017_486653_0014	513

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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).

Findings/Faits saillants :

1. The Licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

This inspection was triggered in stage one of the RQI for resident #030.

Interviews with PSWs # 102 and #129, indicated that they document any observations related to skin in the point of care (POC) electronic documentation system, under skin. PSWs also indicated that any changes that they observe in a resident's skin condition are reported to the registered staff.

Interviews with registered staff indicated that PSWs report concerns related to residents skin conditions verbally to them, and once they are notified, they will assess the resident and make a decision about what treatment or referrals are required.

Review of a head to toe skin assessment, completed on an identified date in 2018, for resident #030 identified that the resident had identified altered skin integrity. There was no corresponding progress note or referral to any other discipline.

Review of the POC documentation for the same time period had no documentation of skin issues.

A progress note documented on an identified date in 2018, identified that resident #030

had an identified area of altered skin integrity.

Review of the POC documentation for this date revealed no documentation of skin concerns.

Review of the Minimum Data Set (MDS) assessment completed on an identified date in 2018, indicated that resident #030 had identified areas of altered skin integrity. An interview with the RPN #117 who completed the MDS assessment identified that they would have relied on the information they received from the PSW when completing this assessment, and may not have verified the PSWs observations with the registered staff or other skin assessments.

A progress note written on an identified date in 2018, identified that the resident had identified areas of altered skin integrity.

Review of the POC documentation of the above mentioned date revealed no concerns.

Interview with the wound care nurse, RN #130, identified that they had assessed the resident, did not identify any areas of altered skin integrity, and that they proceeded to recommend skin care treatment based on their assessment.

Interview with RPN #111 identified they did not recall the condition of the residents skin for that date.

Interview with RPN #117 identified that there was lack of clear direction as to what information related to skin observations PSWs are expected to enter into POC.

Interview with the DOC identified that there was a lack of consistency and collaboration related to the skin and wound program. [s. 6. (4) (a)]

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 collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Dining observation was conducted as a mandatory inspection protocol during the RQI. As a result of the initial observation additional observations were conducted by the inspector.

Observation of lunch service on the second floor north resident home area on August 31, 2018, identified the daily and weekly menu listed choices of tropical fruit salad and lemon butter cake. Observation identified desserts were portioned and placed on a tray in the servery area and only two pieces of cake were observed. PSW #104 served desserts to residents in the dining room, placing fruit in front of many residents and providing cake to two residents.

In an interview, PSW #104 stated that they were aware of the residents likes and that there were two pieces of cake provided to residents who liked cake. PSW #104 indicated that residents were not offered choices for dessert. In an interview, Dietary Aide #103 stated that more cake was available in the servery and that PSW staff should know they could ask for it.

In an interview, Manager of Dietary Services #128 indicated that it was the expectation that all residents be offered choice of desserts at meals. They further indicated that they believed the staff on the second floor north home area were working there a long time and knew the residents and what they might like. The Manager of Dietary Services acknowledged that the residents should still be offered the choice at each meal, and they had failed to ensure the planned menu items were offered. [s. 71. (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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

a. Dining observation was conducted as a mandatory inspection protocol during the RQI. As a result of the initial observation additional observations were conducted by the inspector.

Observation of lunch service on the sixth floor south resident home area (RHA) on August 28, 2018, showed that at approximately 1220 hours trays of portioned desserts including sliced peaches and apple crumble cake were placed on a shelf above the steam table in the servery area. At this time soup was being served to residents in the dining room.

In an interview, dietary aide #101 indicated that they had placed the desserts on the shelf above the steam table as the residents did not like to have the fruit too cold.

An additional observation was conducted on August 31, 2018, on the second floor north and at approximately 1220 hours, portioned desserts including tropical fruit salad and lemon butter cake were placed on a shelf above the steam table in the servery area. At this time beverages were being served to residents in the dining room.

Interview with Dietary Services Supervisor #105 indicated that the desserts should be kept in the cooler until being served.

In an interview, Manager of Dietary Services #128 indicated that desserts would be placed on the counter in the servery prior to being served as the residents did not like the fruit to be very cold. They further indicated that it was not acceptable to place the desserts on the shelf above the steam table as it was too hot in that location, and it would

affect the quality of the desserts. They acknowledged that the desserts were not stored using methods to preserve taste, nutritive value, appearance and food quality.

b. A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on April 9, 2018, regarding several issues in the home. Review of the complaint indicated that the complainant had found rotten fruit had been served to their family member and had reported this to the Registered Dietitian (RD) in the home.

In an interview, RD #127 indicated that they had received a concern from a family member of a resident who told them that the fruit was rotten. The RD confirmed that some of the pureed fruit had been spoiled and was discarded and remade. The RD indicated they brought this issue forward to Manager of Dietary Services #128 as it was a dietary issue rather than a nutrition care issue.

In an interview, Manager of Dietary Services #128 indicated that the concern was brought forward regarding the spoiled fruit which was pureed fruit. The Manager of Dietary Services indicated that they believed the dietary staff were preparing the pureed fruit too far in advance and had since changed the process to ensure that snacks were prepared no more than one day prior to service. They acknowledged that the pureed fruit was not prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

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 food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a personal assistance service device (PASD) used under section 33 of the Act to assist a resident with a routine activity of living was removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained.

This inspection was triggered in stage one of the RQI related to increased physical abuse for resident #011.

During this inspection, the inspector observed resident #011 with an identified restraint device in use. The resident was observed to be quiet and responsive behaviours were not noted.

Review of MDS assessment completed on an identified date in 2018, identified the resident's assessed cognitive abilities and indicated the resident had declined since the previous assessment. The MDS assessment also indicated several responsive behaviours that resident #011 was known to exhibit.

Review of a signed Consent for the Use of a Physical /Chemical Restraint Form, signed on an identified date in 2018, identified the prescribed use for the device.

Further inspector observations identified that the device was being used at times other than what were indicated in the resident's plan of care.

In separate interviews, PSWs #114, #119, #120, and RN #113, indicated the purpose of the device and the times when it should be used according to resident #011's plan of care, and RN #113 acknowledged that use of the device beyond the times identified in the plan of care constituted a restraint.

In an interview, RPN #118, who was also the BSO lead, indicated that resident #011 received identified medications which were effective at managing the residents responsive behaviours and there was no reason for the use of the device.

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 that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained, to be implemented voluntarily.

WN #5: 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 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.

During the initial tour of the home on August 28, 2018, a review of the posted MOHLTC inspection reports was conducted. During this review it was identified that a licensee copy of report #2018_526645_0004 was posted in a binder on the main floor of the home. The report contained residents personal health information including medical diagnoses, responsive behaviours, falls history, specific injuries, skin conditions and pain.

In an interview the CEO indicated that the home posts public copies of all MOHLTC inspection reports in the binder located on the main floor of the home. They stated that licensee copies should not be posted to protect residents' personal health information. The CEO acknowledged that as the licensee report #2018_526645_0004 was posted they had failed to ensure that the residents' right to have their 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. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact

information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the last two years for the long term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

During the initial tour of the home on August 29, 2018, Inspectors #643 and #727 conducted review of MOHLTC public inspection reports which were posted in the home in a binder, in the main floor lobby. Review of the binder failed to reveal a copy of the public inspection report #2017_420643_0002, with report date of February 22, 2017.

In an interview, the CEO indicated that the home posted all public inspection reports in the binder on the main floor of the home, and acknowledged that the above mentioned public inspection report had not been posted in the home in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations. [s. 79. (3) (k)]

Issued on this 17th day of October, 2018

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

Original report signed by the inspector.