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
May 28, 2018	2018_526645_0004	000315-18	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)

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): April 18, 19, 20, 25, 26, 27, 30, May 2, 3, 2018.

This complaint, Log# 000315-18, is related to Plan of Care, Complaints policy and procedure.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) coordinator, Clinical Educator, personal support workers (PSW), and Registered Nursing staff members.

During the course of the inspection, the inspector(s) reviewed the health record for resident #008, reviewed policies and procedures for skin and wound management, fall prevention management, Medication Administration Records (MAR) and complaint policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

A complaint was received on January 4, 2018 regarding resident #008. The complainant, who is a family member of resident #008, stated that RN #101 did not solicit family members' assistance for medication administration as stated on the resident plan of care. RN #101 refused to come back and re-try to administer the resident's medications when they refused.

A review of the plan of care effective on November 4, 2016, indicated resident #008 was resistive to care related to an identified medical condition and may refuse to take medications. The intervention section of the plan of care directs staff members to do the following: to solicit family assistance if resident is non-compliant with medication administration, to re-try to administer the scheduled/PRN medication 10-15 minutes after and obtain family input as needed.

During an interview, RN #101 stated that the care was not provided as specified in the plan of care. RN #101 reiterated that resident #008 refused to take medication at times and the plan of care directs staff members to retry after 10-15miniutes and/or solicit assistance from family members. RN #101 admitted to saying to the family that they were too busy to come back in 10-15min to try administer the medications on November 4, 2016. RN #101 stated that her response to the family member was inappropriate and does not align with the direction of the plan of care.

An interview with the DOC confirmed that RN #101 was disciplined for unprofessional behaviour and inappropriate care. The plan of care directed staff members to involve family members when resident #008 refused medication and/or to retry 10-15miniuts after. The DOC stated that the nurse did not provide the care as specified in the plan.

2. Resident #008's plan of care on an identified date indicated the resident was at high risk for falls and directed staff members to provide a specific intervention and document the findings. The review of the resident's #008 record did not indicate any documentation of the task.

An interview with RN #100 revealed that the home used a paper form called "Monitoring List" to monitor residents who are at risk for fall. RN #100 reiterated that staff PSWs were expected to provide the intervention as specified in the plan and document findings. They confirmed documentation was not completed as specified in the plan of care.

An interview with the DOC confirmed that there is no documentation to verify if the care was provided to the resident. Staff members are expected to follow the plan of care; and

document findings. The DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system and is complied with.

According to O.Reg.79/10, s.48(1) (1) Every licensee shall ensure that there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

A complaint was received on January 4, 2018, regarding resident #008. The complainant, who is a family member of the resident, stated that resident #008 had altered skin condition on an identified part of resident's #008 body and the home did not know how it happened.

A review of the home's progress note on October, 31, 2016, revealed that RN #100 assessed the altered skin condition and documented that the resident had a fall. Further record review revealed that there was no head to toe assessment, no HIR, no incident reporting and post fall assessment completed.

The home's policy on "Fall-prevention and Management, #604-HC-HC" states that when a resident has fallen, registered staff should complete the following: post fall assessment, a head to toe assessment, assess for bruises, laceration, deformities and complete a Head Injury Routine (HIR) if injury to the head is suspected; complete an internal incident report and conduct a thorough investigation of the fall incident.

An interview with RN#100 confirmed that there were no assessment completed for this fall. No post fall assessment nor incident reporting was completed. RN #100 revealed that it is the expectation of the home to complete a thorough assessment as per policy. They re-iterated that the resident was receiving a blood thinner and the altered skin condition to the identified body part could have been from a fall. As such, a head injury routine, head to toe and thorough post fall assessment is required for this type of fall to determine the cause of the fall and the level of injury. RN #100 confirmed that none of the above assessments were completed as indicated in the policy.

An interview with the DOC confirmed that it is the expectation of the home that registered staff complete a head to toe assessment, determine the cause of fall, complete incident reporting and conduct a post fall assessment. The DOC conformed that RN #100 did not follow the home's fall and fall prevention policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy on pain and pain management is complied with.

According to O.Reg.79/10, s.48(1) (4) Every licensee of a long-term care home shall ensure that a pain management program to identify pain in residents and manage pain are developed and implemented at the home.

A complaint was received on January 4, 2018 regarding resident #008. The complainant stated that resident #008 had altered skin condition and notified RN #101. The complainant stated that resident #008 verbalized pain localized to the area of injury but the nurse did not complete assessment or provide treatment.

The home's progress note on the identified date, revealed that the resident's daughter notified RN#101. Further record review indicated that there was no pain assessment completed.

The home's policy on "Pain Management Program- Assessment, Goals, Strategies and Evaluation, #612-HC-HC" states that Registered staff are to conduct a pain assessment when a resident or family member of a resident reported pain. The assessment should include location, severity of pain, effects, quality of the pain and interventions.

An interview with RN#101 revealed that it is the expectation of the home to conduct pain assessment when pain is verbalized by a resident or family member of the resident. RN #101 confirmed that for this incident, there was no pain assessment completed.

An interview with the DOC confirmed that it is the expectation of the home that registered staff complete pain assessment when pain is verbalized, provide appropriate treatment if needed and document the findings. [s. 8. (1) (a),s. 8. (1) (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 the home institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system and is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint was received on January 4, 2018 regarding resident #008. The complainant, who is a family member of the resident, stated that resident #008 had altered skin condition on their body part and the home did not know how it happened.

A review of the home's progress note on the identified date, revealed that RN#100 assessed the altered skin and documented that the resident had a fall. The resident's Medication Administration Record (MAR) indicated that resident was receiving a blood thinner. The home's policy on "Fall, Fall-prevention and management, #604-HC-HC" states that when a resident has fallen, registered staff should complete the following: post fall assessment, a head to toe assessment, assess for bruises, laceration, deformities and complete a Head Injury Routine (HIR) if injury to the head is suspected; complete an internal incident report and conduct a thorough investigation of the fall incident. Further record review revealed that there was no head to toe assessment, no incident reporting and post fall assessment were completed.

An interview with RN#100 confirmed that there were no assessment completed for this fall. No post fall assessment nor incident reporting was completed. RN #100 revealed that it is the expectation of the home to complete a thorough assessment, using a clinically acceptable tool, when a resident had a fall. They re-iterated that the resident was receiving a blood thinner and the altered skin condition on the identified body part could have been from the fall. A head injury routine, head to toe and post fall assessment is required for this type of fall to determine the cause of the fall and the level of injury. RN #100 confirmed that none of the above assessment were completed.

An interview with the DOC confirmed that it is the expectation of the home that registered staff complete an assessment using a clinically acceptable tool, determine the cause of the fall and develop an intervention to prevent the fall from happening again. [s. 49. (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 that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written internal policy comply with the regulations for initiating written complaints.

A complaint was received on January 4, 2018 regarding resident #008. The complainant stated that the home refused to accept emailed complaint letters and told them that the home only accepts verbal or written complaints and written email complaints are not accepted. The complainant stated that this limits the residents' right to complain by imposing limitation to the format and ways of lodging concerns.

A review of a document, written by the CEO on February 14, 2017, confirmed that the complainant was advised to bring forward complaints in writing or verbally but not via email system as the home does not accept complaints via email. A review of the home policy on "Dealing with Written Complaints, NO: A025" stated that it is the home's policy that written complaints via email are NOT accepted.

An interview with the CEO, on April 18, 2018, confirmed that the policy of the home "Policy No: A025" discourage complainants from bringing written complaints in an email form. The CEO reiterated that the policy will be reviewed immediately and the necessary change will be implemented. [s. 21.]

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 resident exhibiting altered skin integrity, including skin breakdown, received 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.

A complaint was received on January 4, 2018 regarding resident #008. The complainant stated that resident #008 had altered skin condition from unexplained fall and the home did not know how it happened.

A review of the home's progress note on the date, revealed that the resident's daughter notified RN#101 about the skin injury. The RN documented altered skin condition from unknown cause. Record review did not indicate if skin assessment was completed. No documentation was found to verify if the resident was assessed for skin break down.

An interview with RN#101 confirmed that on the identified date, the resident's daughter

notified them about the altered skin condition. During the interview RN#101 stated that the cause of the identified skin injury was unknown. RN #101 confirmed that skin assessment was not completed and re-iterated that if a resident has an altered skin condition, the registered staff are to complete a thorough skin assessment in a clinically acceptable tool.

An interview with the DOC confirmed that it is the expectation of the home that registered staff complete a head to toe assessment and/or a Braden Scale skin assessment when residents have an altered skin condition. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #008, who exhibited altered skin condition, received immediate treatment and interventions to reduce or relieve pain, and promote healing.

A complaint was received on January 4, 2018 regarding resident #008. The complainant stated that resident #008 had altered skin condition on the identified date and notified RN #101 but there was no pain assessment completed. The complainant stated that resident #008 verbalized pain localized to the area of injury but the nurse did not complete pain assessment or provide treatment.

The home's progress note on November 1, 2016, revealed that the resident's daughter notified RN#101 about the skin injury. Record review did not indicate if pain assessment was completed.

The home's policy on "Pain Management Program- Assessment, Goals, Strategies and Evaluation, #612-HC-HC" directs Registered staff to conduct pain assessment when a resident exhibited or verbalized pain. The assessment should include location of the pain, severity of pain, extent, effects and quality of the pain.

An interview with RN#101 revealed that it is the expectation of the home to conduct pain assessment when pain is verbalized by a resident or reported by the family member of the resident. RN #101 confirmed that for this incident, there was no pain assessment completed.

An interview with the DOC confirmed that it is the expectation of the home that registered staff complete pain assessment when pain is verbalized, provide appropriate treatment if needed and document the findings. [s. 50. (2) (b) (ii)]

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Issued on this 29th day of May, 2018

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

Original report signed by the inspector.