Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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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
Jan 29, 2020	2020_767643_0002	016315-19	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 #016315-19 - related to prevention of abuse and neglect, and skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Director of Programs and Services and Personal Support Workers (PSW).

During the course of the inspection, the inspector conducted observations of resident and staff interactions and the provision of care, reviewed resident health records, the home's internal investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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. 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 #010 who was exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment tool that was specifically designed for skin and wound assessment.

A complaint was submitted to the Director from resident #010's family member indicating that when they were discharged from the home they had altered skin integrity. The complaint indicated that the resident had altered skin integrity on both upper extremities.

Review of resident #010's health records showed that they were admitted to the home on an identified date, and had a head to toe skin assessment carried out the following day, which noted two identified areas of altered skin integrity. One area was noted to the resident's right upper extremity, as well as a second on another identified area. A third area of altered skin integrity was identified in a second head to toe assessment on the same day, on resident #010's right upper extremity, which occurred in the home.

Review of progress notes showed six days following admission, RN #108 documented they had changed dressings on both of resident #010's upper extremities. No head to toe assessment was identified showing assessment of an area of altered skin integrity on the resident's left upper extremity.

Review of the home’s investigation notes showed that PSW #120 noted an area of altered skin integrity on resident #010’s left upper extremity. The investigation notes further showed that PSW #120 reported the skin alteration on resident #010’s left upper extremity to RN #108, who changed the resident’s dressings. The investigation notes showed that RN #108 told the DOC that they received report that resident #010 had an area of altered skin integrity on the left upper extremity and changed dressings on both of resident #010’s upper extremities.

PSW #120 was not available for interview at the time of inspection.

In an interview, RN #108 indicated that it was the process in the home that when a resident had a new area of altered skin integrity the registered staff were expected to complete an incident report to document the new skin alteration. The RN indicated that a head to toe assessment was the tool used in the home to document on the type of altered skin integrity, measurements and any characteristics of the area. RN #108 indicated that they did not recall the resident, and noted they had a head to toe assessment completed following admission to the home. RN #108 indicated that they did not believe a head to toe assessment was carried out for area of altered skin integrity on resident #010’s left upper extremity.

In an interview, DOC #101 indicated that it was the expectation for registered staff upon becoming aware of an alteration in skin integrity for a resident would be to complete an incident report. The incident report would direct the staff to complete a head to toe assessment for the resident to assess the area of altered skin integrity. The DOC acknowledged that a head to toe assessment was not carried out for resident #010's new area of altered skin integrity on the resident’s left upper extremity and should have been. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, 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.