

**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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de
Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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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
Sep 8, 2021	2021_780699_0013	004198-21, 004199- 21, 004200-21, 006649-21, 009346-21	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

PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 19-21, 23, 26-29, 2021.

The following Critical Incident System (CIS) intakes were inspected:

- Log 009346-21 [2937-000012-21] related to fall with injury; and**
- Log 006649-21 [2937-000010-21] related to injury of unknown cause.**

The following follow up intakes were inspected:

- Log 004200-21 related to Compliance order #001 from inspection #2021_780699_0002;**
- Log 004198-21 related to Compliance order #002 from inspection #2021_780699_0002; and**
- Log 004199-21 related to Compliance order #003 from inspection #2021_780699_0002.**

During the course of the inspection, the inspector(s) spoke with the Director of Care, Associate Director of Care, Resident Assessment Instrument (RAI) Coordinator, Environmental Service Supervisor, Registered practical nurses, and personal support workers.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

- Falls Prevention**
- Personal Support Services**
- Prevention of Abuse, Neglect and Retaliation**
- Responsive Behaviours**
- Safe and Secure Home**

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

- 3 WN(s)**
- 1 VPC(s)**
- 1 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 # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2021_780699_0002		699
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2021_780699_0002		699
O.Reg 79/10 s. 55.	CO #001	2021_780699_0002		699

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 was provided to three residents as specified in the plan related to bed rail use.

Three residents were observed in bed with two quarter bed rails in place on two separate days. One resident was observed to be exhibiting behaviours while in bed.

The residents' care plan did not indicate that the residents required bed rails. Staff stated that the above mentioned residents did not require bed rails and if bed rail use was not indicated in the resident's plan of care, then they should not be in use. One resident exhibited responsive behaviours that placed the resident at increased risk of entrapment and injury. Residents were required to be appropriately assessed for use of bed rails prior to being used to ensure their safety.

Sources: Observations, residents' care plans, and interview with staff. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

- 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
- 2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
- 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
- 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written description of the personal support services and nursing program.

The inspector requested a written description of the home's personal support services (PSS) and nursing program. The ADOC indicated that the home had a PSS and nursing program but did not have a written terms of reference for them.

Sources: PSS and Nursing program description, and interview with staff. [s. 30. (1) 1.]

2. The licensee has failed to ensure that the restorative care, personal support services and nursing programs were evaluated and updated annually.

The inspector requested to review the home's program evaluation for the restorative care, personal support services and nursing programs for 2020. The ADOC stated that the program evaluations were not completed for the above programs in 2020.

Sources: 2020 program evaluations and interview with the ADOC. [s. 30. (1) 3.]

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 the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor of the home.

On three dates, the temperatures were not recorded for the first, second and third floor resident common areas at the 02:00hours (hrs) temperature check. The Environmental Service Supervisor (ESS) confirmed that resident common areas temperatures should be measured. The home's policy titled "Guidelines for the prevention and management of hot weather-related illness", IC-063, last revised May 2021, indicated the following: record indoor temperatures of one resident common area of every floor of the home".

Sources: Temperature logs 2021, Guidelines for the prevention and management of hot weather-related illness", IC-063, last revised May 2021, and interview with the ESS. [s. 21. (2) 2.]

2. The licensee has failed to ensure the temperatures were documented at least once every morning, once every afternoon between 12:00hrs, and 17:00hrs, and once every evening or night.

On two separate dates, the temperature in the home was recorded only at 0740hrs and 1801 hrs. There were no temperatures documented between 12:00hrs to 17:00hrs. The ESS indicated temperatures were recorded only twice a day. The home's policy titled "Guidelines for the prevention and management of hot weather-related illness", IC-063, last revised May 2021, indicated the following: frequency is three times a day; once in the morning, once in the afternoon between 12:00hrs -17:00hrs., and once in the evening or night.

Sources: Temperature logs 2021, Guidelines for the prevention and management of hot weather-related illness", IC-063, last revised May 2021, and interview with the ESS. [s. 21. (3)]

Issued on this 27th day of October, 2021

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

Original report signed by the inspector.

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : PRAVEENA SITTAMPALAM (699)

Inspection No. /

No de l'inspection : 2021_780699_0013

Log No. /

No de registre : 004198-21, 004199-21, 004200-21, 006649-21, 009346-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Sep 8, 2021

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 : Tracey Comeau

To Copernicus Lodge, you are hereby required to comply with the following order(s)
by the date(s) set out below:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee will be compliant with s. 6 (7). of the LTCHA.

Specifically, the licensee must ensure:

1. That for residents, bed rails will not be used unless the resident has been assessed for the use of bed rails and specified in the plan of care.
2. Conduct audits upon receipt of this order for three months, of resident home areas to identify any bed rails that are being used and if the resident has been assessed for the use of bed rails and specified in the plan of care. The audit must include who conducted the audit, date of the audit, name of the resident audited and any actions taken.

Grounds / Motifs :

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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

1. 1. The licensee has failed to ensure that care set out in the plan of care was provided to three residents as specified in the plan related to bed rail use.

Three residents were observed in bed with two quarter bed rails in place on two separate days. One resident was observed to be exhibiting behaviours while in bed.

The residents' care plan did not indicate that the residents required bed rails. Staff stated that the above mentioned residents did not require bed rails and if bed rail use was not indicated in the resident's plan of care, then they should not be in use. One resident exhibited responsive behaviours that placed the resident at increased risk of entrapment and injury. Residents were required to be appropriately assessed for use of bed rails prior to being used to ensure their safety.

Sources: Observations, residents' care plans, and interview with staff. [s. 6. (7)]

An order was made by taking the following factors into account:

Severity: Bed rails were being used when the residents were not assessed for the use of them, nor were the bed rails included in the residents' plan of care. There was minimal risk to the residents as there were no injuries or harm as result of the use of bed rails.

Scope: This non compliance was widespread as three out of three residents reviewed had bed rails in place when they did not require it.

Compliance history: Three Voluntary Plans of Correction (VPC) to the same subsection. (699)

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

Nov 26, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
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foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of September, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Praveena Sittampalam

Service Area Office /

Bureau régional de services : Toronto Service Area Office