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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2015	2014_237500_0026	T-018-14	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

NITAL SHETH (500), JULIET MANDERSON-GRAY (607), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 15, 16, 17, 18, 22, 23, 2014.

During the course of the inspection, the inspector(s) spoke with the chief executive officer (CEO), education and continuous quality improvement (CQI) coordinator, director of care (DOC), assistant director of care (ADOC), manager of dietary services, dietary services supervisor, environmental services supervisor, executive assistant to the CEO, registered dietitian, resident assessment indicator (RAI) coordinator, director of environmental services, registered nursing staff, personal support workers (PSWs), dietary aides, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
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
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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 O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

At approximately 3:30 p.m., on December 15, 2014, the inspector observed the following: One window in activity room on 1 North, opened the full size of the window panel, which is 40 centimetres wide. The window was open to the outdoors, overlooking the parking lot one floor below. The activity room door is kept open and unlocked, and is accessible to residents. No staff or residents were present in the room when this window was observed. The window was pointed out to the evening charge nurse, who informed the maintenance department. The charge nurse informed the inspector on December 15, 2014, at 6:00 p.m., that the window blocker had been repaired and the window no longer opened the entire width. On December 16, 2014, at 10:00 a.m., the inspector observed that the window now opens maximum of 10 centimetres wide. [s. 16.]

2. On December 17, 2014, the inspector observed that the large windows in resident rooms 401, 406, 601 open more than 15 centimetres.

The window in room 401 opened 17 centimetres, room 406 opened 15 and 1/2 centimetres and room 601 opened 16 centimetres.

The home's director of environmental services was informed and stated that he/she was not aware that the windows opened more than 15 centimetres. The home's director of environmental services states that the maintenance staff checks the windows monthly, but they do not measure the openings to know exactly how far they open. The director stated that the above noted rooms will be checked and it will be ensured that they do not open more than 15 centimetres. Further, he will have the maintenance staff check the windows monthly with a 15 centimetre form, to ensure that they do not open more than 15 centimetres.

On December 23, 2014, the CEO confirmed that above mentioned windows had been repaired and no longer open more than 10 centimetres as per the home's policy. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #2: 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 review of a plan of care for resident #16 revealed that the resident has a fall on an identified day in November 2014.

Interview with the charge nurse confirmed that the incident report was initiated after the fall and started head injury routine (HIR) for the resident, however there is no post fall assessment completed. The home does not have a clinically appropriate tool specifically designed for the falls. [s. 49. (2)]

2. A review of the progress notes and incident reports for resident #2 revealed the resident had falls in June, July, October and November 2014.

A review of the home's assessment record revealed that the resident had no post fall assessments completed after any of the above mentioned falls.

Interview with the charge nurse confirmed that he/she was not aware of the post fall assessment tool and the home does not conduct a post fall assessment after a fall. [s. 49. (2)]

3. A review of the incident report revealed that resident #17 had a fall in December 2014 in his/her bathroom.

A review of the plan of care of the resident revealed that a post fall assessment was not conducted using a clinically appropriate tool specifically designed for the falls for the resident after the fall.

Interview with the charge nurse confirmed that the home does not have post fall assessment tool and usually they complete the incident report and document in the progress notes.

A review of a policy #604-HC-NS, titled Falls Prevention and Management Program, dated June 2010, revealed that the post fall risk assessment is completed when a resident has had 3 falls in a period of 3 months or less and documentation for post fall risk assessment is completed by all disciplines in the multidisciplinary electronic charting using the title post fall risk assessment.

Interview with the DOC confirmed that the post fall risk assessment is only completed after 3 consistent falls by multidisciplinary team and it is documented under progress notes under the title post fall risk assessment. [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 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observation conducted on December 15, 2014, revealed that on 3 south there was a unlabelled dirty razor and a tube of Vaseline sitting on the ledge of shower area. [s. 229. (4)]

2. Interview with the PSW and registered nursing staff confirmed that all personal equipment including the above mentioned razor and Vaseline should be labelled.

Observation conducted on December 15, 2014 at 12:20 p.m., on 2 north dining room, revealed that nursing staff do not perform hand hygiene after clearing dishes and before serving food to the residents. Three PSWs were observed not performing hand hygiene after clearing dishes and performing other tasks on several occasions.

Interview with manager of dietary services, dietary service supervisor and director of care (lead of the infection prevention and control program) confirmed that the all staff should perform hand hygiene during meal service after clearing the soiled dishes. The DOC confirmed that resident's personal items should be labelled. [s. 229. (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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #4: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

Observation conducted on December 15, 2014, at 12:20 p.m., in 2 north dining room revealed that more than 3 residents were provided plastic spoons for dessert.

Interview with the manager of dietary services confirmed that providing plastic spoon to any resident is not acceptable as it is a dignity issue. The home has enough silver spoons in the kitchen. [s. 3. (1) 1.]

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #15's plan of care revealed that the resident has impaired vision and needs glasses.

Interview with the PSW confirmed that the resident does not wear glasses.

Interview with the charge nurse confirmed that the family took the glasses home as the resident does not wear it.

Interview with the RAI Coordinator confirmed that the plan of care should represent the resident's current health status. The plan of care should be revised for above mentioned residents for above mentioned information to provide clear directions to the staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

A review of the incident report revealed that resident #16 had a fall in November 2014, in his room, the resident was completely undressed and incontinent of urine.

Interview with the PSW confirmed that the resident is incontinent of bladder and most of the time the resident's floor is wet with urine and they need to wipe the floor to prevent resident from falling.

Interview with the charge nurse confirmed that the resident had a fall in November 2014 at night, and the resident was incontinent of urine. The resident was assessed by psycho- geriatric team on December 2014, and it was recommended to put a night light in the resident's room or to keep the light on in the washroom and leave the door open to prevent falls at night. The care plan was not revised to include this information. [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are provided with fluids that are adequate in quantity.

Observation conducted on December 15, 2014, at 12:00 p.m., in 2 north dining room revealed that most of the residents were provided half of the glass (75 mL) of juice.

Interview with the dietary aide confirmed that they are serving half glass because residents spill it on the tables.

Interview with the PSW confirmed that they serve half glass of juice because resident have too much fluids at meals and they can not finish all of them.

A review of the policy #714-HC-DS, titled Adequate Fluid Intake, revised June 2013, indicated125 mL juice is the minimum amount of the fluids to be offered to each resident.

Interview with the manager of dietary services confirmed that the staff should provide 125 mL of juice at all meals. [s. 11. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Observation conducted on December 15, 2014, at 12:00 p.m., in 2 north dining room revealed that one PSW was serving soup and another was serving tea/ coffee to the residents. Resident #19 was served thickened tea on the table prior to the main course.

Interview with the manager of dietary services confirmed that meals should be serve course by course according to the policy. Tea/ coffee should be served after the main course unless it is specified in the plan of care of the resident. [s. 73. (1) 8.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies.

Observation conducted on December 18, 2014, at 10:30 a.m., of 1 north medication cart revealed that there were two keys in the narcotic drawer.

Interview with the registered nursing staff confirmed that the keys should not be stored in the narcotic drawer.

Interview with the ADOC confirmed the home's expectation is that only medications are stored in the narcotic drawer. [s. 129. (1) (a)]

Issued on this 9th day of January, 2015

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

Original report signed by the inspector.