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
Jul 23, 2015	2015_398605_0015	T-001652-15	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

SARAH KENNEDY (605), SLAVICA VUCKO (210), 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): June 4, 5, 8, 9, 10, 11, 12, 15 & 16, 2015.

During the course of the inspection, the inspector(s) spoke with the chief executive officer (CEO), director of care (DOC), assistant director of care (ADOC), environmental services supervisor (ESS), registered dietitian (RD), registered nursing staff, RAI coordinator, personal support workers (PSWs), dietary aide, residents, family members and substitute decision makers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
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
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **4 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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The door leading to the multi-purpose room on the ground floor was observed to be unlocked and unattended on June 5, 2015, at 9:10 a.m. and 4:35 p.m., and on June 8, 2015, at 9:15 a.m. This room contains an unlocked door which leads to a secure outdoor courtyard. No staff or residents were in or around the door at the time of the observations.

Interview with the Chief Executive Officer (CEO) on June 8, 2015, confirmed that the door to the multi-purpose room is to be kept locked when not attended by staff or a responsible individual, but that the door leading from the multi-purpose room to the secure outdoor courtyard must be kept unlocked because it is a fire door. According to the CEO, the multi-purpose room is booked for use by staff, families and tenants of the adjoining retirement residence.

The home's written policy titled "Special Function Request Sheet/Common Room Spaces Booking and Security", Policy # A062, dated November 2, 1995, revised October 2000, and February 2003, stated that the policy's purpose is to ensure that the rooms are returned to their original state and rooms are secured, and that department managers are responsible for locking all doors upon completing the activity/job duties. The policy further states that for every function booked, there must be an assigned staff or responsible person known to Copernicus Lodge to ensure that the above is adhered to.

During a follow-up interview on June 8, 2015, the CEO stated that the locks to the multi-purpose room had just been changed, and the process for booking the multi-purpose room was changed and now requires that the person booking the room sign out the key from reception, and sign to declare that the room has been locked when returning the key.

When checked by the inspector on June 8, 2015, at 5:50 p.m., the door to the multi-purpose room was found locked. [s. 8. (1)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On June 4, 2015, during a tour of the home at approximately 10:00a.m., it was observed by inspector #178 that the lock on the door leading into the servery from the communal dining area on 2 South (2S) was broken. A staff member was present in the servery at this time.

On June 16, 2015, at 10:00a.m., the Environmental Services Supervisor (ESS) confirmed that the lock on the 2S servery door was broken and not functioning properly. The ESS stated that the expectation is for the lock on the door to always be functioning so that the door can be kept closed and locked when the area is not being supervised by staff.

Later on in the same day, at 11:13a.m., it was observed by inspector #605 that the lock had been replaced and was functioning properly. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Review of resident #008's records and interviews with staff #125, staff #127, and staff #128 confirmed that resident #008 is incontinent. Registered staff #128 was unable to find any record to indicate that a continence assessment which includes the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, was ever done for this resident, using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The Director of Care (DOC) confirmed that it is the home's policy and practice to assess incontinent residents using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, on admission and with any change in condition which would affect continence. This assessment instrument includes the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. The DOC confirmed that this assessment was not done for resident #008 on admission, or later when the resident's continence status declined. [s. 51. (2) (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 resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #4: 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. (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of the Minimal Data Set (MDS) assessment, for resident #001, indicates that the resident has impaired vision and does not wear visual appliances.

Review of the written plan of care, indicates that the resident has impaired vision related to the aging process, is unable to read regular print, and that the resident should continue to use compensatory mechanism for decreased vision.

Interview with PSW #110 confirmed that the care plan indicates the resident should wear eye glasses but he/she has not worn eyeglasses for the last six months. Interview with the RAI Coordinator revealed that a family member had a discussion with the registered nursing staff and stated that the resident used to wear eye glasses but no longer needs them.

Review of the written plan of care and interview with the RAI Coordinator confirmed that resident #001's written plan of care was not reviewed and revised when the resident's care needs changed in relation to using eye glasses. [s. 6. (10) (b)] (210) [s. 6. (10) (b)]

2. Staff interviews and review of resident #008's plan of care confirmed that his/her plan of care was not reviewed and revised when the resident's care needs changed after return from hospital.

Resident #008's written plan of care, stated that the resident is able to feed independently, wash his/her hands after toileting, wash face and upper body, reposition independently in bed, perform oral hygiene independently once set up by staff, and is transferred using an identified device.

Interviews with staff #125, #127 and #128 confirmed that since returning from hospital the resident had changes in his/her ADL status, and these changes were identified.

Interview with the DOC confirmed that resident #008's written plan of care was not updated after the resident returned from hospital with a change in condition. [s. 6. (10) (b)]

Issued on this 7th day of August, 2015

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

Original report signed by the inspector.