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
Nov 14, 2017	2017_493652_0016	024115-17	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

NATALIE MOLIN (652)

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): October 30, 31, and November 1, 2, 2017

The following complaint intake were inspected log #024115-17

During the course of the inspection, the inspector(s) spoke with Chief Executive Officers (CEOs), assistant director of care (ADOC), director of care (DOC), registered practical nurses (RPNs) and registered nurse (RN)

During the course of the inspection, the inspector(s) conducted a tour of the home; observed staff to resident interactions and the provision of care, resident to resident interactions; reviewed complaints records,conducted records review, reviewed the home's policy for complaints.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (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).

Findings/Faits saillants :

1. The licensee of a long-term care home shall ensure that there is clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

A complaint was received from the family of resident #008 related to care and services in the home. During the course of this complaint inspection, the following evidence related to the plan of care was issued for this resident.

Record review of resident #008's progress notes on an identified date reveal the Assistant Director of Care (ADOC) spoke with the Subsitute Decision Maker (SDM) regarding care. According to the progress note, the SDM agreed to the home administering an identified medication to the resident. Further record review indicated that the ADOC contacted the physician and an order was received to discontinue the identified medication at the specific time and administer only if the resident has a sleeping problem.

Record review of resident #008's physician's orders on an identified date revealed a phone order received by the ADOC from MD #102.The order stated to discontinue the identified medication at the specific time and give this identified medication as needed (PRN). The doctor's order did not mention that the identified medication was only to be administered if resident has sleeping problem as mentioned in the progress on an identified date.

Record review of resident #008's written plan of care on an identified date revealed due to a diagnose resident sometimes does not sleep well, up in the middle of the night, attempt to redirect to bed, provide comfort. This written plan of care further mentions resident #008 prefers to go to bed at an identified time and also notes that resident does have difficulty sleeping at night and will be awake during the night.

Record review of resident #008's Medication Administration Records (MARs) for an identified period revealed that resident #008 was given an identified medication on at least 19 different occasions over a nine month period of time.

Record review of resident #008's specified Assessment Note on an identified date revealed there has been a significant concern and resident #008 was not generally observed to be tearful or depressed.

Interview with RN #100 revealed he/she could not recall why his/her progress notes on an identified date mentions an identified medication to be administered only if resident has sleeping problems.

Interview with MD #102 revealed an identified medication was used to address specified conditions of resident #008.

Interview with ADOC #101 on an identified date revealed he/she transcribed the ordered and did not mention that the identified medication was to be administered only if resident has sleeping problems PRN. ADOC revealed this order did not provide clear directions to staff. [s. 6. (1)]

Issued on this 12th day of December, 2017

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

Original report signed by the inspector.