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
Feb 26, 2021	2021_780699_0002	003181-20, 007577-20, 016443-20, 019596-20, 024761-20, 025767-20, 025769-20, 000659-21, 000661-21	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), NAZILA AFGHANI (764)

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): January 11-15, 18-22, and 25, 2021

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

-Log 007577-20 (CIS 2937-000005-20), 025767-20 (CIS 2937-000020-20), and 025769-20 (CIS 2937-000021-20) related to alleged abuse;
-log 003181-20 (CIS 2937-000002-20), 016443-20 (CIS 2937-000010-20), and 019596-20 (CIS 2937-000011-20) related to falls;
-log 000659-21 (CIS 2937-000001-21) and 000661-21 (CIS 2937-000002-21) related to resident to resident abuse; and
-log 024761-20 (CIS 2937-000019-20) related to infection outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), agency manager (AM), activation assistants (AA), and residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
7 VPC(s)
3 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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Progress notes showed the resident was involved in several separate incidents where the resident exhibited responsive behaviors toward several co-residents and staff members. In four of the documented incidents, the resident was assigned a one to one staff who were unable to effectively manage the resident's behavior.

Review of the home's policy indicated that every resident behavior care plan would describe the following: behaviors exhibited by the resident, triggers to the behaviors, and interventions which have been found to be successful in addressing the behaviors. Review of the resident's care plan showed a focus was created regarding the resident's responsive behavior but no triggers were specified.

During interview with two RPNs, they were not able to define triggers for the resident's behaviors and recalled the behavior management interventions as one to one monitoring and giving the resident their prescribed medication.

The responsive behavior team lead, stated the trigger for resident's behavior was

personal care.

The RN and the DOC, stated that no triggers were identified in the resident’s responsive behaviour care plan and the care plan interventions were not effective in managing the responsive behavior; especially in the last incident when resident was on one to one monitoring.

Sources: Copernicus Policy titled Responsive Behavior Program, RCS 7.15.1, Specialized programs documents, progress notes, care plan, assessment, electronic medication administration record (eMAR), interview with RN, RPNs and DOC. [s. 55. (a)]

2. The licensee has failed to ensure that the direct care staff were advised at the beginning of every shift regarding residents whose behaviors posed a potential risk to the others.

Review of the home's policy indicated that all staff should be informed each shift when residents require heightened monitoring. Any new responsive behaviors and any behaviors that may cause risk to the resident or others should also be communicated to staff.

A color coded system behavioral risk level system was established in the home, and staff were responsible to understand the system. PSW #105 indicated that one resident was a yellow risk level, indicating the resident behaviours may cause risk to residents and/or staff if not monitored and handled properly. However, review of the resident’s care plan showed that the resident was a red risk level, which indicated that the resident had behaviours that will cause risk to staff and/or residents if not monitored and handled properly.

A PSW stated that nothing was communicated with them regarding high risk residents or the coloured coded system at the beginning of the shift.

A RN stated that the nurse had the responsibility to inform the PSWs regarding high risk residents, especially if they were from agency and did not have access to the computer and Point of Care (POC).

During interview with the DOC, they stated that they expected their staff to know the color coded system which could be found in care plan and beside the resident’s name card on the wall, but was not sure if new staff knew about color dot system and if the

information regarding high risk residents was communicated.

Sources: Copernicus Lodge Specialized programs : 'What you need to know', Copernicus Lodge policy titled responsive behavior program, RCS 7.15.1, interview with PSWs, RPN and the DOC. [s. 55. (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from sexual abuse by a resident.

For the purposes of definition 'sexual abuse' in subsection two of Ontario Regulation 79/10 means, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The resident's behavioral care plan showed an intervention was in place: to protect other residents if unable to protect themselves.

Review of three critical incident system (CIS) reports and home investigation notes showed three critical incidents were reported that the resident abused three residents on separate dates.

The resident was assessed to have mild cognitive impairment. Progress notes recorded that the resident had exhibited abusive behaviors toward co-residents and staff on eight separate dates. In four of these incidents, the resident was on 1:1 monitoring and the 1:1 staff was not able to manage the resident.

Staff stated that the resident had a history of exhibiting behaviours toward co-residents. Staff added that the resident was targeting vulnerable residents, and interventions in place were not protecting the other residents.

The BSO team lead and DOC #110, stated that interventions were not successful to protect the other residents from abuse by the resident.

Sources: Copernicus Lodge Zero Tolerance of Abuse and Neglect, RCS 7.7.45, RAI-MDS assessment, progress notes, care plan, critical incident system reports, home investigation notes, interview with staff. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that incidents related to resident to resident abuse by a resident toward other residents was reported to the Director.

Review of a memo, updated on February 5, 2019 showed that staff were provided direction regarding critical incidents and reporting certain matters to the Director.

The resident's care plan showed staff should report the incidents of suspected abuse towards other co-residents.

Progress notes documented that 5 incidents of suspected resident to resident abuse were identified by staff.

Staff stated that the incidents were not reported to management or the Director, as they were not sure if they constituted abuse.

DOC #110 stated that any suspected abuse should be immediately reported to the Director.

Sources: Copernicus Lodge Zero Tolerance of Abuse and Neglect policy, RCS 7.7.45, established January 2021, resident #005's progress notes, behavioral notes, interview with staff. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was safe and secure for residents.

As per Directive #3, all long-term care homes were required to conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19. Residents with symptoms (including mild respiratory and/or atypical symptoms) must be isolated and tested for COVID-19.

Staff stated that residents were screened twice daily for signs and both typical and atypical symptoms of COVID-19, including twice daily temperature and oxygen saturation level checks. If a resident exhibited any signs and symptoms that were indicative of COVID-19, the resident would be immediately isolated and tested. A resident exhibited signs and symptoms of COVID-19 on three separate dates. There was no indication if the resident was assessed or tested for COVID-19. DOC #110 confirmed that the expectation would be that the resident would be screened and tested if they exhibited symptoms of COVID-19.

Sources: Resident's progress notes, physician orders, interviews with staff. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident's plan of care was followed related to bed mobility.

A resident required two-person assistance with their activities of daily living. As per the PSW, they indicated that the resident requested for assistance personal care, and would assist the PSW, so they did not call a second staff member to assist with the care. The staff member tried to move the resident to provide care and the resident indicated they were in pain. The staff member stopped and asked a second staff member to assist with care. The expectation for staff was to follow directions in the care plan when providing care.

Sources: Resident's care plan, interviews with staff. [s. 6. (7)]

2. The licensee has failed to ensure that the resident's fall interventions were documented in their plan of care.

Review of a CIS report indicated that a fall intervention was initiated as a fall intervention when the resident returned from the hospital post fall. Review of the resident's progress notes, and care plan did not indicate that the fall intervention was initiated. Staff stated that the fall interventions initiated for the resident post fall and it was the expectation that the intervention would be documented in the care plan.

Sources: Resident's care plan, progress notes, Kardex, interviews with staff. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy that promotes zero tolerance for abuse and neglect of residents was complied with.

The home submitted two CIS reports related to alleged abuse of two residents.

Review of the home’s policy titled “Zero Tolerance of Abuse and Neglect”, RCS 7.7.45, established January 2021, outlined the following procedure when there is an incident of alleged neglect:
-the implicated employee will be suspended with pay from active duty or discharge to follow;
-the DOC/designate, in collaboration with Human Resources and other members of the senior management team, will ensure that a detailed investigation is completed immediately. The DOC will send a report including results of investigation and actions taken in response to the incident via CIS within 10 days or earlier if requested by the Director;
-the DOC/designate ensures that all information regarding the allegation and investigation is documented;
-at a minimum the following individuals should be interviewed by the DOC/designate, and the Director of Human resources with union representation as required: person implicated in the abuse or neglect allegation, any witnesses, and any staff having knowledge of abuse or neglect. Documentation must include: what happened, when it happened, where it happened, who was involved and describe precipitating factors, if known.

A PSW was identified as working on the floor the night of the incident, however the home did not interview them; the police had interviewed the staff member the following day. The PSW continued to work in the home after their interview with the police. The home did not identify the second PSW implicated in the suspected abuse. The DOC indicated that the investigation was still ongoing however acknowledged that there were some gaps in the implementation of the policy.

Sources: Record review of “Zero Tolerance of Abuse and Neglect”, RCS 7.7.45, established January 2021, investigation notes, critical incident system reports, interview with staff. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015 was not restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home.

Inspector #764 observed that the doorway of a resident's room was blocked with a piece of furniture and on the other side, a PSW was preventing the resident from coming out. The following day, Inspector #764, found that the doorway of the resident's room was blocked with furniture, and a recycling bin.

The resident was confined in their room by blocking the door and preventing them from coming out. A RPN stated they were preventing the resident from coming out of their room because they wanted to prevent them from wandering and spreading infection.

A PSW stated they were preventing the resident from coming out due to their responsive behaviours.

DOC #110, stated that preventing the resident from coming out of their room by using furniture to block the doorway was considered a barrier prohibited by the legislation.

Sources: Home restraints policy No. 81, Resident #015's progress notes, care plan , PCC records, interview with staff and Inspectors #764's observation. [s. 30. (1) 5.]

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 no residents are restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report to the Director was made within 10 days of becoming aware of the alleged incident of abuse involving two residents

The home submitted a CIS reports related to alleged abuse. The CIS was not amended with the outcome of the investigation. The DOC stated that the investigation was still on-going, however the CIS should have been amended with that information.

Sources: CIS report, and interview with DOC #110. [s. 104. (2)]

2. The home submitted a CIS report related to alleged abuse. The CIS was not amended with the outcome of the investigation. The DOC stated that the investigation was still on-going, however the CIS should have been amended with that information.

Sources: CIS report, and interview with DOC #110. [s. 104. (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 the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director, to be implemented voluntarily.

WN #9: 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 staff participated in the implementation of the infection prevention and control program.

Inspector #699 made the following observations on January 12, 2021:
- observed a PSW in a resident room assisting resident with fluids, with a gown, mask and face shield on, however was not wearing gloves. They completed hand hygiene after doffing their gown. A 'P' sign was noted on door frame, indicating resident was positive for an infection;
-observed a PSW enter a room with appropriate personal protective equipment (PPE) on. They assisted the resident with meal set up, they took off their PPE in the correct order, however did not complete hand hygiene. The staff member then began to put on new PPE. Inspector then observed staff remove the PPE again, and completed hand hygiene appropriately. They donned gloves first then gown.

The PSW stated that they should have been wearing gloves during resident interactions. They had initially worn gloves when delivering a meal tray to the resident, and removed the gloves to exit the room, however the resident requested for assistance with their beverages.

The PSW stated that hand hygiene should have been completed after removing PPE, and the correct order to don PPE is gown, then gloves. The DOC acknowledged that the IPAC program was not followed.

Sources: Observations conducted January 12, 2021, interviews with staff. [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.

Issued on this 11th day of March, 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), NAZILA AFGHANI (764)

Inspection No. / No de l'inspection : 2021_780699_0002

Log No. / No de registre : 003181-20, 007577-20, 016443-20, 019596-20, 024761-20, 025767-20, 025769-20, 000659-21, 000661-21

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Feb 26, 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 : Roxanne Adams

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee must be compliant with s. 55. (a) of the O.Regs 79/10.

Specifically, the licensee must:

-Ensure all direct care staff who are involved in resident care are provided training on the home's Responsive Behaviours Program, RCS 7.15.1. This training must also include, but not limited to, what is identified as responsive behaviours, how to manage residents who exhibit behaviours, and what referrals must be made for residents exhibiting responsive behaviours.
-Maintain a written record of the training material, names of staff trained, when training occurred and who provided the training.
-Reassess and revise resident #005's plan of care related to their responsive behaviours utilizing an interdisciplinary approach, including the resident's substitute decision maker (SDM). Keep a record of who participated.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful

interactions between and among residents.

Progress notes showed the resident was involved in several separate incidents where the resident exhibited responsive behaviors toward several co-residents and staff members. In four of the documented incidents, the resident was assigned a one:one staff who were unable to effectively manage the resident's behavior.

Review of the home's policy indicated that every resident behavior care plan would describe the following: behaviors exhibited by the resident, triggers to the behaviors, and interventions which have been found to be successful in addressing the behaviors. Review of the resident's care plan showed a focus was created regarding the resident's responsive behavior but no triggers were specified.

During interview with two RPNs, they were not able to define triggers for the resident's behaviors and recalled the behavior management interventions as 1:1 monitoring and giving the resident their prescribed medication.

The responsive behavior team lead, stated the trigger for resident's behavior was personal care.

The RN and the DOC, stated that no triggers were identified in the resident's responsive behaviour care plan and the care plan interventions were not effective in managing the responsive behavior; especially in the last incident when resident was on 1:1 monitoring.

Sources: Copernicus Policy titled Responsive Behavior Program, RCS 7.15.1, Specialized programs documents, progress notes, care plan, assessment, electronic medication administration record (eMAR), interview with RN, RPNs and DOC.

An order was made by taking the following factors into account:
Severity: There was actual harm to the residents;
Scope: One out of four residents were affected representing an isolated incident.

Compliance history: 8 Written Notifications (WN), 14 Voluntary plans of

correction (VPC) and 1 Compliance order related to a different subsection of the legislation in the past 36 months. (764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 28, 2021

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA.

Specifically, the licensee must ensure:

-All residents are protected from sexual abuse.
-Provide re-training on the home's Zero Tolerance of Abuse and Neglect, with a specific focus on sexual abuse, to all direct care staff, on the secured behavioural unit, including agency staff.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from sexual abuse by a resident.

For the purposes of definition 'sexual abuse' in subsection two of Ontario Regulation 79/10 means, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The resident's behavioral care plan showed an intervention was in place: to protect other residents if unable to protect themselves.

Review of three critical incident system (CIS) reports and home investigation notes showed three critical incidents were reported that the resident abused three residents on separate dates.

The resident was assessed to have mild cognitive impairment. Progress notes recorded that the resident had exhibited abusive behaviors toward co-residents and staff on eight separate dates. In four of these incidents, the resident was on 1:1 monitoring and the 1:1 staff was not able to manage the resident.

Staff stated that the resident had a history of exhibiting behaviours toward co-residents. Staff added that the resident was targeting vulnerable residents, and interventions in place were not protecting the other residents.

The BSO team lead and DOC #110, stated that interventions were not successful to protect the other residents from abuse by the resident.

Sources: Copernicus Lodge Zero Tolerance of Abuse and Neglect, RCS 7.7.45, RAI-MDS assessment, progress notes, care plan, critical incident system reports, home investigation notes, interview with staff.

An order was made by taking the following factors into account:
Severity: There was actual harm to the residents;
Scope: Several residents were affected representing a widespread incident.
Compliance history: 1 Compliance order related to the same subsection of the legislation in the past 36 months. (764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 02, 2021

Order # / No d'ordre : 003 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident’s money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24. (1) of the LTCHA.

Specifically, the licensee must:

-Ensure any and all incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is reported immediately to the Director.
-Provide training to all registered staff on reporting requirements, with focus on when to report sexual abuse.
-Develop and implement a written reporting procedure that includes how and when to report to the Director when abuse occurs. This written report procedure will be made accessible at all nursing stations.

Grounds / Motifs :

1. The licensee has failed to ensure that incidents related to resident to resident abuse by a resident toward other residents was reported to the Director.

Review of a memo, updated on February 5, 2019 showed that staff were provided direction regarding critical incidents and reporting certain matters to the Director.

The resident's care plan showed staff should report the incidents of suspected abuse towards other co-resident.

Progress notes documented that 5 incidents of suspected resident to resident abuse were identified by staff..

Staff stated that the incidents were not reported to management or the Director, as they were not sure if they constituted abuse.

DOC #110 stated that any suspected abuse should be immediately reported to the Director.

Sources: Copernicus Lodge Zero Tolerance of Abuse and Neglect policy, RCS 7.7.45, established January 2021, resident #005's progress notes, behavioral notes, interview with staff.

An order was made by taking the following factors into account:
Severity: There was minimal risk/harm to residents;
Scope: Seven out of nine incidents were not reported, indicating there was a pattern.
Compliance history: One Written notification (WN) was issued to the home related to the same subsection. (764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 02, 2021

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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:

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 revision 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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 26th day of February, 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