Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Original Public Report

Report Issue Date: December 16, 2022	
Inspection Number: 2022-1421-0001	
Inspection Type: Critical Incident System	
Licensee: Copernicus Lodge	
Long Term Care Home and City: Copernicus Lodge, Toronto	
Lead Inspector Manish Patel (740841)	**Inspector Digital Signature** Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2022.12.16 14:13:26 -05'00'
Additional Inspector(s) April Chan (704759)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 6 - 9, 2022

The following intakes were completed in this Critical Incident System (CIS) inspection:

- Intake #00003464, Intake #00003774, Intake #00006972 and Intake #00011240 related to unwitnessed fall of resident resulting in injury.
- Intake #00005387, Intake #00006178 and Intake #00011771 related to resident fall resulting in injury.
- Intake #00006554 related to Injury of unknown cause.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a staff member followed routine hand hygiene practices as required by the infection prevention and control (IPAC) program.

The licensee failed to ensure that the hand hygiene program was followed by a staff member in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the licensee did not ensure that Routine Practices and Additional Precautions were followed as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary
The home's Hand Hygiene Policy indicated that proper hand hygiene is the single most effective method of limiting the transmission of infections. Alcohol based hand rub should be used if no visible dirt is present on the hands. Staff members should clean their hands prior to and after touching the resident or their environment.

PSW #107 was delivering meal trays and setting up meals for residents in their room and did not perform hand hygiene between care of two residents. PSW #107 acknowledged that they should have performed hand hygiene between the residents' rooms, but they had forgotten.

PSW #107 was observed performing hand hygiene with alcohol-based hand rub prior to assisting the next resident during the meal tray delivery service. The home's expectation was to perform hand hygiene between residents when providing meal tray service.

There was risk of infectious disease transmission when routine hand hygiene practices were not followed by a staff member.

Sources: the home's hand hygiene policy (#IC068, revised June 2022), observations, interviews with PSW

#107, IPAC Lead and CEO.

Date Remedy Implemented: December 6, 2022
[704759]

WRITTEN NOTIFICATION: PAIN MANAGEMENT PROGRAM

NC #002 Written Notification pursuant to LTCHA, 2007, s. 152 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 48 (1) 4.

The licensee has failed to comply with the pain management program to identify and manage pain for a resident.

In accordance with O. Reg. 79/10, s. 8 (1) b, the licensee is required to ensure that once resident is triggered for pain, pain assessment and ongoing monitoring for pain is done and must be complied with.

Specifically, staff did not comply with the home's policy# NO87, titled "Pain Management Program", last reviewed in January 2022.

Rationale and Summary
A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care.

A Resident had pain. The home's physician had assessed the resident and ordered a test. The resident was transferred to the hospital after 8 days for the test and diagnosed with an injury.

During this time, the resident was assessed using a pain scale indicating pain on multiple days.

The home's Pain Management Program Policy # NO87 required that the resident with complaints of pain would be assessed and monitored on an ongoing basis. Policy also assigned responsibility of conducting and documenting pain assessment to the Registered Nurse (RN)/Registered Practical Nurse (RPN).

Since the onset of the resident's pain, to the point of hospital transfer, pain assessments were not performed consistently for the resident as required by the Pain Management Program Policy# NO87.

The Assistant Director of Care (ADOC) #102 and RPN # 112 acknowledged that pain assessments were not done consistently since the resident was first noticed with pain, and the resident should have been monitored for pain on an ongoing basis until the time of transfer to the hospital, as required by the Pain Management Program Policy# NO87.

There was a risk of unmanaged pain for the resident when pain assessments were not completed as per the home's Pain Management Program.

Sources: Pain Management Program Policy# NO87, resident's assessment and progress notes, ADOC #102 and RPN # 112 interviews.

[740841]