Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 8, 2024	
Inspection Number: 2024-1421-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Copernicus Lodge	
Long Term Care Home and City: Copernicus Lodge, Toronto	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature**
Additional Inspector(s) Parimah Oormazdi (741672)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16 - 19, 22, 23, 25 and 26, 2024.

The following intake(s) were inspected:
- Intake: #00113396 related to the Proactive Compliance Inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Medication Management

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee failed to ensure that the resident's plan of care was revised when an intervention was no longer necessary for the resident's fall prevention management.

Rationale and Summary:

A resident's written plan of care indicated that they were at high risk for falls and required a specific intervention. However, the resident was not observed to have the

intervention in place. A staff member stated that the intervention was not used as a fall prevention intervention at the time of observation. Another staff member told the inspector that the fall intervention had been discontinued and was no longer being used by the resident.

The Assistant Director of Care (ADOC) verified that the intervention was no longer necessary as the resident was not at high risk of falls and discontinued it. They acknowledged that the resident's written plan of care should have been revised to reflect this change and confirmed that it was revised a day after the observation.

Further review of the resident's written plan of care indicated the discontinuation of the intervention.

There was low risk to the resident when the plan of care was not revised.

Sources: Observations, resident's clinical records, interviews with staff members.

[739633]

Date Remedy Implemented: April 18, 2024

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that the infection prevention and control lead (IPAC lead) carried out their responsibilities related to the hand hygiene program.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary:

A registered staff member was observed entering a resident's room who was on contact precaution and handed them a bottle of lotion and exited the room, however they did not perform hand hygiene before or after resident/ resident environment contact. The staff member acknowledged the inspector's observations. IPAC lead and the Director of Care (DOC), both confirmed that the staff were required to perform hand hygiene before and after resident/resident environment contact.

Due to staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Observations, interviews with staff members, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

[741672]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

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Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked.

The licensee has failed to ensure medications were stored in an area that was secured and locked.

Rationale and Summary:

Two medications were observed left unattended on a medication cart on a resident home area. There were residents within the vicinity and a resident was observed ambulating close to the unattended medication cart. After a few minutes, the registered staff member returned to the medication cart and handed one of the medications to a resident. The other medication remained on the medication cart when the staff member went to another resident's room and left the medication unattended again.

By failing to ensure that drugs were stored in an area or medication cart, that was secured and locked can increase the risk of harm to the residents.

Sources: Observations and interviews with staff members.

[741672]