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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 22, 2023

Inspection Number: 2023-1421-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Copernicus Lodge

Long Term Care Home and City: Copernicus Lodge, Toronto

Lead Inspector	**Inspector Digital Signature**
Nital Sheth (500)	Nital Sheth Digitally signed by Nital Sheth Date: 2023.04.13 15:20:21 -04'00'

Additional Inspector(s)
Kim Lee (741072)

Inspector Dorothy Afriyie (000709) was also present in this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s), February 21-24, 27-28, and March 1-3, 6-10, 13, 14-15 (off-site), 2023.

The following intake(s) were inspected:
- Intake related to duty to protect
- Intake related to a compliant raised multiple concerns related to residents' care
- Two complaint intakes related to duty to protect, fall incident resulted in injury, and multiple care related concerns
- Two intakes related to falls incident resulted in injury were competed during this inspection.

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

Skin and Wound Prevention and Management

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
According to the Minister's Directive (August, 2022), the licensee is required to have provisions around the home's implementation of all required public health measures as well as infection prevention and control practices.

The home's visiting policy indicated that all staff, caregivers, students, volunteers and general visitors will receive a new surgical mask at the entrance screening station, both for indoor and outdoor visits. They must change into a new surgical mask before proceeding to the surveillance testing area or resident floors or the outdoor garden visiting area.

On February 21, 2023, the inspector observed that the security allowed some people entering in the home without changing into a new surgical mask while conducting screening at the entrance of the home.

Infection Prevention and Control (IPAC) lead acknowledged that there is a risk of cross contamination, and people entering in the home should change into a new mask.

Sources: Observations, Ministry's Directive COVID-19 response measures for long-term care homes (August, 2022), home's visiting policy (IC-080, revised October 10, 2022), interview with the IPAC lead. [500]

Date Remedy Implemented: February 21, 2023

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff who provided direct care for that resident.

Rationale and Summary
An order was given for a resident's bed mobility for a specified frequency. RPN #104 transcribed the order with incorrect frequency. Given the way that the order was transcribed, documentation entries indicating that the resident's order for bed mobility was implemented for six instances instead of 12 in day. RPN #104 stated that they had transcribed the order this way because it was the practice at the LTCH. Nursing Supervisor #105 stated that the order was written as RPN #104 had transcribed because it reminded registered staff to monitor PSW staff to implement the order for residents. RPN #104 and Nursing Supervisor #105 stated that the LTCH used an identified visual aid that was available in resident rooms to ensure residents were order for bed mobility was implemented. The order as transcribed, did not provide clear direction for the resident's care related to bed mobility.

The order was an intervention to reduce and prevent impaired skin integrity. Providing clear direction on the frequency of the order was necessary to effectively manage the resident's skin

integrity concerns.

Sources: Interview with staff, review of resident's bed mobility related record and plan of care. [741072]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed.

Rationale and Summary
PSW #102 and PSW #103 were present when resident #001 experienced a fall. PSW #102 and PSW #103 stated that at the time of the fall, the resident was not applying with an identified device and was not required to have it to be applied. RPN #104 responded to the fall. RPN #104 stated that the resident was not applied with an identified device wearing a seat belt and was not required to be applied it.

RPN #104 stated that the identified device order was discontinued at an earlier date, but the plan of care was not updated.

The plan of care showed there was a historical order for the identified device, and that order was discontinued. The order was not in effect at the time of the fall, however the plan of care was not updated after the order was discontinued.

The plan of care contained outdated care information. This did not result in resident harm however the plan of care did not reflect the most current care needs of the resident at the time of the fall.

Sources: Interviews with staff, review of resident's plan of care. [741072]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint raising concerns related to multiple residents' care.

The physician made an order for resident #009 to ensure that the resident did not have a specified symptom. This order was not implemented as RPN #128 did not find an equipment to implement this order. The Nursing Supervisor acknowledged that RPN #128 should have followed the order and report to the management if they were not able to find the equipment.

The resident was at risk for developing a specific health condition as the order was a precautionary measure to prevent this from happening.

Sources: Progress notes, interviews with Nursing Supervisor. [500]

WRITTEN NOTIFICATION: Duty to Protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect resident #011 from physical abuse by PSW #127.

Rationale and Summary:
According to O. Reg. 246/22, s. 2 (1), "physical abuse" means, subject to subsection (2), "the use of physical force by a resident that causes physical injury to another resident".

Resident #011 reported that the staff member abused them. The resident was identified with an injury. The resident was consistent in their statement during the home's investigation. PSW #127 denied abusing the resident, however they confirmed some components of the resident's report about the allegation.

The DOC acknowledged that PSW #127 physically abused resident #011 and caused an injury afterwards.

Sources: CIS report, Policy on Prevention of Abuse and Neglect of a Resident (HR011, revised August 8, 2022), home's investigation notes, and interview with PSW #114, DOC and others. [500]

WRITTEN NOTIFICATION: Complaint Procedure

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that they immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home.

Rational and Summary:
The MLTC received a complaint raising concerns related to residents' care.

The inspector identified that the complainant sent an email to the DOC and ADOC raising concerns related to the residents' care on an identified day. The complainant had sent another email about the same concerns to the Director of Human Resources (HR) a month later.

The home's policy on complaints management indicated that complaints expressed in writing including written communication in any form such as a letter, note, email or fax shall be immediately submitted to the MLTC as per legislative requirements.

The DOC and HR acknowledged that these written complaint from the complainant was not forwarded to the Director.

Sources: Emails conversations between the complainant and management, the home's policy on Complaints Management (#AO25, reviewed July 4, 2022), interviews with the DOC and Director of HR. [500]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to ensure that a resident's weight was measured and recorded for a given month.

Rationale and Summary
A complaint was received that resident #001's nutrition and hydration care needs had not been met or addressed by the LTCH over a period of time.

Nursing Supervisor #105 stated that residents are weighed monthly. Nursing Manager #105 stated that weight would be done at the beginning of the month, unless the resident was not present at the time. If a resident was not present, the weight would be done upon the resident's return in that same month. Nursing Supervisor #105 stated that the weight was not recorded for resident #001 for an identified month.

Review of the resident's admission indicated that the resident was present at the LTCH for the entire identified month, however their weight was not measured and recorded. There was no documented rationale for not weighing the resident.

Dietitian #129 acknowledged that resident #001's weight measurement was missing.

The resident was identified at high-nutrition risk, in accordance to their plan of care. Failing to record the weight hindered the LTCH's ability to detect a significant change in the resident's weight earlier.

Sources: interview with staff, review of resident's weight measurements and dietary assessments [741072]

WRITTEN NOTIFICATION: Dining and Meal Services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary:
On February 21, 23, 2023, the inspector observed that juices, milk for beverages and bread were served on the dining tables half an hour prior to the scheduled lunch time and the residents arrived in the dining rooms.

The home's policy on meal service indicated that milk must be kept in fridge and poured within 15 minutes of meal service.

The Manager of Dietary Services indicated that serving milk before the mealtime is not safe according to the regulations set by the Department of Public Health. They have advised the dietary aides to keep milk in fridge until 15 minutes before mealtime.

Sources: Observations, Policy on Meal Service (#DS-03-04, revised December 2022), and interview with Manager of Dietary Services. [500]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that a documented record of a complaint was made that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up required.

Rationale and Summary
The SDM had care concerns about an incident with a resident and made a specific request to the home. DOC #100 stated that ADOC #106 had provided a response to the SDM about their specific request, however ADOC #106 stated that they did not provide a response to the SDM.

Notes made by RPN #108, and Physician #109 on two separate occasions indicated that SDM had verbalized concerns and made the specific request related to the incident concerning the

resident. The LTCH did not document or provide a response to the SDM's request related to their concern.

By failing to provide a response to the SDM, the home did not communicate or facilitate a mutually understood resolution of the raised concern, if any.

Sources: Interview with staff, the resident's record, the LTCH's Complaints Management policy. [741072]