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

Original Public Report

Report Issue Date: July 9, 2024	
Inspection Number: 2024-1421-0003	
Inspection Type: Critical Incident	
Licensee: Copernicus Lodge	
Long Term Care Home and City: Copernicus Lodge, Toronto	
Lead Inspector Nrupal Patel (000755)	**Inspector Digital Signature** Nrupal Patel Nrupal Patel 2024.07.16 09:46:32 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10-14, 17, 20-21, 2024.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

- Intake: #00106582 / CI # 2937-000003-24, Intake: #00107164 / CI # 2937-000005-24, Intake: #00108780 / CI # 2937-000007-24, Intake: #00112755 / CI # 2937-000011-24, Intake: #00115502 / CI # 2937-000014-24, Intake: #00115832 / CI # 2937-000015-24 , Intake: #00116219 / CI # 2937-000017-24 - related to disease outbreak.
- Intake: #00107497 / CI # 2937-000006-24, Intake: #00111599 / CI # 2937-000009-24, Intake: #00112767/ CI # 2937-000012-24, Intake: #00115992 / CI # 2937-000016-24, Intake: #00116284 / CI # 2937-000018-24 - related to falls prevention and management.
- Intake: #00110328/ CI # 2937-000008-24 - related to resident care and service.

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

Resident Care and Support Services
Infection Prevention and Control
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 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

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

Rationale and Summary:

A resident's plan of care indicated that a specific intervention should have been applied as tolerated when the intervention was first initiated . During an observation on the morning of June 12, 2024, the resident was observed without the specific

intervention while seated. The Personal Support Worker (PSW) confirmed that the resident was not using the specific intervention.

The Assistant Director of Care (ADOC) mentioned that the intention was to apply the specific intervention for the resident at night due to the resident's falls occurring at night, as the resident did not have a history of falls during the day or evening. They also had other interventions in place during the day and evening to prevent injuries related to falls.

ADOC confirmed that the current plan of care did not provide clear directions to staff on the application and removal of the specific intervention for resident.

On June 12, 2024, ADOC updated the plan of care to include instructions for staff on the application and removal of the specific intervention.

Failing to include clear instructions for staff in the written plan of care for the resident posed a low risk of injury given their history of falls and other interventions in place. However, it could have led to inconsistencies in care.

Sources: Observation of resident on June 12, 2024; interview with ADOC. [000755]

Date Remedy Implemented: June 12, 2024

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief

Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer appointed under the Health Protection and Promotion Act were followed in the home.

Specifically, The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings dated April 2024 section 3.1 on page 24, required Alcohol Based Hand Rub (ABHR) must not expired.

Rationale and Summary:

On June 10, 2024, Inspector observed two Purell brand wall mounted ABHR located in the dispensers on the wall on 6 south (6S) Unit area both with past expiry dates, including May 2024 and November 2023.

Registered Nurse (RN) confirmed that the wall mounted ABHR products were expired.

Director of Care (DOC) and the Infection Prevention and control (IPAC) Lead both acknowledged that ABHR products were expired.

Failing to ensure that the hand sanitizer was not expired may have increased the risk of transmitting infectious agents.

Sources: Observations of 6S unit on June 10, 2024; interviews with RN, IPAC Lead and DOC; and a record review of 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings,' dated April 2024.

[000755]

COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

A) Provide education to PSW on the home's Falls Prevention and Management and Safe Transferring policies including their role and responsibility in ensuring the proper use of safe transferring and mobility devices.

B) Document the education from step A and maintain a record, including the date of education and the staff member who provided the education.

C) Conduct audits for care related to transfer and mobility provided by a specific PSW. Audits are to be completed for the PSW, for a minimum period of two weeks, three times per week on a specific resident to ensure that the care provided to the resident is as specified in the resident's plan of care related to transfer and mobility.

D) Maintain a record of the audits conducted, to include, but not limited to: audit dates, person(s) completing the audits, audit findings and any actions taken in response to the audit findings.

Grounds

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

Rational and Summary:

The resident was assessed to be at risk for falls. The plan of care indicated that they were dependent on a wheelchair for mobility and required a mechanical lift for transfers.

On March 16, 2024, a PSW found the resident in a different room. The PSW proceeded to walk resident back to their room without the aid of another staff member and without using the specified mobility aid from the care plan. As a result, the resident lost their balance in their room and fell.

The resident was transferred to the hospital the same day and found to have sustained a fracture.

The Home's investigation notes stated that PSW was aware of the resident's plan of care related to transfer and mobility but did not follow the plan of care for resident.

PSW confirmed that they walked with resident and did not follow the plan of care at that time.

The DOC acknowledged that PSW did not follow the plan of care related to mobility and transfer. The expectation was that staff must adhere to the plan of care.

There was harm and injuries to the resident when staff failed to follow their plan of care.

Sources: Resident's clinical records; Homes investigation notes; Interview with PSW and DOC.

[000755]
This order must be complied with by September 16, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the last 36 months, a compliance order was issued under LTCHA, 2007, s. 6 (7) on September 8, 2021 under Inspection # 2021_780699_0013.

This is the first AMP that has been issued to the licensee for failing to comply with

this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.