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

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Public Report

Report Issue Date: December 24, 2024

Inspection Number: 2024-1421-0004

Inspection Type:
Critical Incident
Follow up

Licensee: Copernicus Lodge

Long Term Care Home and City: Copernicus Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26-28, 2024 and December 2-4, 2024.
The inspection occurred offsite on the following date(s): November 29, 2024.

The following intake was inspected in this follow-up inspection:
• Intake: #00123484 was related to plan of care.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:
• Intake: #00120874 [CI #2937-000022-24] was related to a fall with injury.
• Intake: #00123730 [CI #2937-000024-24] was related to an infection prevention and control outbreak.
• Intake: #00124197 [CI #2937-000025-24] was related to a privacy breach.
• Intake: #00126659 [CI #2937-000031-24] was related to an injury not related to a fall.

The following intake(s) were completed in this inspection:
• Intake: #00120529 [CI #2937-000020-24] was related to a fall with injury.
• Intake(s): #00127115 [CI #2937-000033-24] and #00128471 [CI #2937-000037-24] were complaints related to a privacy breach.
• Intake: #00128346 [CI #2937-000035-24/ CI #2937-000036-24] was related to an alleged privacy breach.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1421-0003 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Infection Prevention and Control
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of Assessments, Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Rationale and Summary

A resident was discovered with altered skin integrity, swelling, and pain in their leg. Diagnostic test results

indicated that the resident had an injury.

The home's policy titled "Skin and Wound Care Program," stated that the Personal Support Worker (PSW)'s roles and responsibilities were to "report abnormal or unusual skin conditions to the registered nursing staff. i.e. red or open areas, blisters, bruises, tears, scratches."

A PSW indicated that after they and another PSW transferred the resident, and they removed their sock saw the altered skin integrity. The PSW indicated that they did not inform the a registered nursing staff about this.

Staff indicated that the registered nursing staff was not informed of the altered skin integrity and that the PSW should have collaborated with and inform the registered nursing staff for assessment. Staff acknowledged that had the PSW collaborated with the registered staff, the appropriate assessments and interventions could have been provided to the resident for the injury.

There was a risk that resident did not receive appropriate interventions in a timely manner to the injury, when the interdisciplinary team did not collaborate in their assessment of resident's altered skin integrity.

Sources: Critical Incident System Report #2937-000031-24; resident's clinical records; policy titled "Skin and Wound Care Program" NO-17, last reviewed May 2024; interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to comply with their pain management program when pain was identified for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the pain management program to identify and manage pain was implemented.

Specifically, a registered nursing staff did not comply with the home's pain management program policy when the resident's pain was not assessed using the pain assessment in the resident's electronic health record.

Rationale and Summary

The home's policy titled "Pain Management Program," stated that "pain assessments will be completed on all residents who have been triggered as having pain: each resident with complaints of pain will be assessed and monitored on an ongoing basis" and "as needed when a residents condition changes."

A resident was discovered with altered skin integrity, swelling, and pain. Diagnostic test results indicated that the resident had an injury.

After two PSWs transferred a resident, they noted the resident was in pain. The PSWs informed a registered nursing staff that the resident was in pain.

Electronic records showed that a pain assessment was not completed. A registered nursing staff indicated that both PSWs informed them that the resident was in pain while they were providing medications to residents. The registered nursing staff indicated that they later went to see the resident, but they were asleep. The registered nursing staff acknowledged that they did not complete a timely pain assessment and they should have gone when the PSWs informed them that the resident was in pain.

Staff acknowledged that the expectation for this registered nursing staff was to complete a pain assessment when both PSWs reported to them that the resident was in pain.

Failure to complete a pain assessment for a resident increased the risk of not identifying the resident's source and level of pain.

Sources: CIS Report #2937-000031-24; resident's clinical records; home's investigation notes; policy titled "Pain Management Program" NO-19, last reviewed March 2024; interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

(i) Specifically, the licensee failed to ensure that documented post-outbreak interdisciplinary debrief sessions were conducted in accordance with Section 4.3 of the IPAC Standard for Long-Term Care Homes, last revised September 2023. This included the assessment of IPAC practices that were both effective and ineffective in the management of the outbreak as well as any recommendations to the licensee for improvements in outbreak management practices.

Rationale and Summary
IPAC committee minutes, did not include any evaluation of aspects of outbreak management after the home's outbreak as required by the IPAC Standard.

Staff confirmed outbreak debrief sessions were not completed after the home's outbreak.

The absence of an outbreak review process may impede the home's ability to learn from the previous outbreak management and may contribute to a risk for continuation of ineffective IPAC practices.

Sources: Review of IPAC committee minutes, IPAC Standard and interview with a staff member.

(ii) Specifically, the licensee failed to ensure that there are policies and procedures in place to determine the frequency of cleaning and disinfection using a risk stratification approach, and to ensure that surfaces are cleaned at the required frequency in accordance with Section 5.6 of the IPAC Standard for Long-Term Care Homes, last revised September 2023.

Rationale and Summary
A staff member provided inspectors with a risk matrix document used to determine cleaning frequency in the home. An email from a staff member stated that the home's internal procedure for cleaning frequency was currently being updated.

Staff stated that a risk matrix document was not currently being used to determine cleaning frequency at Copernicus Lodge.

Failure to take a risk stratification approach posed the risk of surfaces not being cleaned at the required frequency.

Sources: Home's risk matrix for cleaning frequency, interview with a staff member, the IPAC Standard revised September 2023.

B) The licensee has failed to ensure that signage indicating the requirement for enhanced IPAC measures was posted at the entrance to a room for a resident on additional precautions.

Rationale and Summary
An inspector observed that additional precaution signage, and personal protection equipment (PPE) supply had been removed from the doorway of a resident's room. The next day, the inspector observed that the additional precaution signage had been replaced on a resident's door, and a PPE supply hanger containing items such as N95 masks, gowns, and gloves.

Staff acknowledged that the additional precaution signage and PPE supplies were removed from this resident's door in error.

Incorrect removal of additional precaution signage from a resident's room poses a risk of PPE not being applied prior to entry and creates a potential for the spread of an infectious disease.

Sources: Observations, interview with staff, resident's electronic records, and IPAC Standard for Long-Term Care Homes.

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