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

Public Report

Report Issue Date: April 8, 2025

Inspection Number: 2025-1421-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Copernicus Lodge

Long Term Care Home and City: Copernicus Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 24-27, 31, 2025, and April 1-4, 7-8, 2025.

The following intake(s) was inspected in the Complaint Inspection:
Intake: #00140565 - related to allegations of physical abuse of a resident

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:
Intake: #00138699 - CIS 2937-000007-25 - related to Infection Prevention and Control (IPAC)
Intake: #00135628 - CIS 2937-000042-24 - related to injury of unknown cause of a resident
Intake: #00140072 - CIS 2937-000012-25 - related to a fall of resident resulting in injury
Intake: #00139351 - CIS 2937-000008-25 - related to alleged emotional abuse of a resident

The following intake(s) were completed in the CIS Inspection:
Intake: #00136542 - CIS 2937-000001-25, Intake: #00137513 - CIS 2937-000003-

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25, Intake: #00138606 - CIS 2937-000006-25 - related to Infection Prevention and Control

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's Zero Tolerance of Resident Abuse & Neglect Policy was complied with when an allegation of suspected abuse occurred; the implicated employee(s) was not immediately placed on paid administrative leave pending further investigation.

A staff member was placed on administrative leave five days after they were identified in a complaint with allegations of abuse received by the home.

Sources: Resident's clinical record, and review of the Home's Zero Tolerance of Resident Abuse & Neglect Policy.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) 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 in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director a written complaint concerning the care of a resident and allegations of abuse by a staff member when it was submitted to the Director five days after it had been received.

Sources: Critical Incident Report, Home's investigation notes.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O.

Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's falls prevention and management program when a registered staff member did not notify the physician of a resident's fall that resulted in pain.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's falls policy indicated for registered staff to notify the attending physician of the fall incident by telephone if there were any new findings or concerns.

Sources: Resident's clinical records, interviews with staff and management, and review of the Home's Falls Prevention & Management Program Policy.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a registered staff member using a clinically appropriate assessment instrument that

was specifically designed for skin and wound assessment when the resident sustained an injury.

Sources: Resident's clinical record, interviews with staff and management, and review of the Home's Skin and Wound Care Program Policy.

WRITTEN NOTIFICATION: CMOH and MOH

NC #005 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 staff providing direct care or interacting with a suspected or confirmed case of COVID-19, were wearing appropriate personal protective equipment (PPE), including eye protection, a gown, gloves, and a well-fitted medical mask or N95 respirator as recommended by the Chief Medical Officer of Health (CMOH).

A resident was placed on droplet-contact precautions (DCP) after they exhibited symptoms. A staff member entered the resident's room wearing a gown and assisted the resident with their meal. The staff member did not wear the appropriate PPE as per the DCP signage posted on the resident's door, which included eye protection, a mask, and gloves.

Sources: Observation; review of a resident's clinical records and recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: February 2025.