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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Original Public Report

Report Issue Date: February 15, 2024
Inspection Number: 2024-1421-0001
Inspection Type: Critical Incident
Licensee: Copernicus Lodge
Long Term Care Home and City: Copernicus Lodge, Toronto

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2024.02.23 09:43:08 -05'00'

Additional Inspector(s)
Ann McGregor (000704)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 9, 10, 11, 12, 15, 16, 18, 19, 2024
The inspection occurred offsite on the following date(s): January 17, 2024 and February 13, 2024

The following intake(s) were inspected:
• Intake: #00097808 - Critical Incident System (CIS) #2937-000026-23 - related to allegation of staff to resident abuse
• Intake: #00098601 - CIS #2937-000029-23 - related to Fall prevention and Management
• Intake: #00103704 - CIS #2937-000032-23 - related to Unknown injury of resident
• Intake: #00105209 - CIS #2937-000034-23 - related to Outbreak Management

• Intake: #00105211 - CIS #2937-000035-23 - related to Injury of resident of unknown cause

The following intakes were completed in this inspection:
• Intake: #00105143 - CIS #2937-000033-23 - related to Fall prevention and Management
• Intake: #00098578 - CIS #2937-000028-23; Intake #00103189 – CIS #2937-000031-23- related to Outbreak Management

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
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: O. Reg. 246/22, s. 12 (1) 3.

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.
The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary
During the inspection, the Linen room door on an identified resident home area (RHA) was unlocked with a towel stuffed inside the door lock. The inspector opened the door and observed linen carts and a secondary electrical door inside. There were no residents in the vicinity at the time of the observation.

The inspector returned to the linen room door on that day and observed that the towel was removed and linen door was locked. A Personal Support Worker (PSW) reported that they observed the towel in the lock and removed the towel, allowing the door to be locked. The PSW acknowledged that the towel should not have been left inside the door.

A Registered Nurse (RN) reported that the door should have been locked and the towel should not have been left inside the lock to prevent the door from closing.

The Director of Care (DOC) acknowledged that the linen room doors were non-residential areas and must remain closed and locked.

There was risk as residents could enter the Linen room and become entrapped or

injured when doors were not kept locked.

Sources: Observations during the inspection period, interviews with RN, PSW, and DOC.

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Date Remedy Implemented: January 9, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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 licensee has failed to ensure that a resident's plan of care for toileting was followed as per their plan of care.

Rationale and Summary
The resident's plan of care indicated they require two person for assistance with toileting.

A PSW stated that the resident used the call bell and called for assistance with toileting. The PSW stated that the resident required two person for toileting, however they changed the resident continence product by themselves as the other PSW was on break. The PSW acknowledged that they did not follow the resident's plan of care when they changed the resident alone.

Assistant Director of Care (ADOC) indicated that the resident needed two person for continence care as the resident was total care. The ADOC acknowledged that the toileting care were not provided to the resident as specified in their plan of care.

Failure to ensure that the resident was provided with care as set out in their plan of care, placed the resident at risk for a potential injury.

Sources: Review of the resident's clinical records; and interviews with PSW, ADOC and other staff

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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)

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 has failed to ensure that the resident was reassessed and the plan of care reviewed when the resident's care needs changed and the resident was no longer able to ambulate.

Rationale and Summary

The resident was found sitting on a chair in their room asleep. A PSW attempted to assist the resident to a standing position to ambulate them back to bed when the resident verbalized that they could not walk and were in pain. The PSW helped the resident to sit and called for the assistance of another PSW and Registered Practical Nurse (RPN).

The RPN advised that when they arrived in the resident's room, the resident complained of pain. They assumed that the resident was experiencing an identified pain, did not complete an assessment, administered analgesic and directed the PSWs to put the resident back to bed and monitor. The RPN acknowledged that they did not complete an assessment when they were informed that the resident could not walk.

The oncoming shift attempted to get the resident out of bed but they refused and complained of pain. As per the ADOC, the resident refused to ambulate.

The ADOC acknowledged that the RPN should have completed a reassessment when the resident's ambulatory status suddenly changed.

Failure to complete a reassessment when the resident's ambulatory status suddenly changed, put them at risk for delayed identification and treatment of changes to their health status.

Sources: Resident's clinical records, CIS #2937-000032-23, interviews with PSWs, RPN, and the ADOC.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee has failed to ensure that responsive behaviour strategies were implemented for a resident when they exhibited a responsive behaviour during transfer.

Rationale and Summary
PSW #115 and PSW #116 both stated when they approached a resident for their transfer, the resident demonstrated responsive behaviors. They continued with preparation of the resident's transfer from wheelchair to bed even though the resident's behaviors increased.

PSW #115 and PSW #116 stated that the resident demonstrated responsive behaviours when they approached the resident to provide transfer assistance. According to both staff, the resident demonstrated behaviours as they began preparation for a transfer. The resident's behaviour further escalated resulting in them sustaining an injury and required the assistance of a third staff.

The resident's care plan under responsive behaviours, directed staff that if they were resistive to care to leave the resident and re-approach in 10 minutes.

The RN acknowledged that the PSWs had not implemented the responsive

behaviour strategies for the resident, and should have re-approached the resident later. The ADOC advised that the PSWs had not utilized the strategies identified in the resident's care plan when they approached the resident to provide transfer assistance.

Failure to implement strategies identified in the resident's care plan put the resident at risk for injury.

Sources: CIS report #2937-000035-23, resident's clinical records, interview with PSW #115, PSW #116, RN, ADOC and others.

[000704]

WRITTEN NOTIFICATION: INFECTION CONTROL AND PREVENTION

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

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

Specifically, Section 9.1 (b) “the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program”, including the four

moments of hand hygiene.

Rationale and Summary
During a meal observation, residents at three tables, were observed entering the dining room and started their meals, without performing or receiving assistance with hand hygiene.

The home's hand hygiene policy directs staff to perform or assist residents with hand hygiene before meals or snacks.

A PSW acknowledged that they did not assist the residents with hand hygiene prior to their meals.

The IPAC Lead and DOC both acknowledged that staff were required to perform or assist residents with hand hygiene before meals or snacks.

Staff failure to assist residents with hand hygiene as required by routine practices increased the risk of transmission of infection in the home.

Sources: Observation of meal service, LTCH's Hand Hygiene Policy #IC068, last revised July 9, 2022, Infection Prevention and Control Standard for Long Term Care Homes, revised September 2023, interview with IPAC Lead, PSW and the DOC

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

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.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, Revised September 2023". Specifically, the IPAC lead failed to ensure that the hand sanitizing wipes used for assisting residents to perform hand hygiene before meals included 70-90% Alcohol-Based Hand Rub (ABHR) as required by Additional Requirement 10.1 under the IPAC standard.

Rationale and Summary

During a meal service, staff were observed assisting residents with hand hygiene using hand sanitizing wipes prior to their meal service. IPAC Lead and the DOC both confirmed that they used the hand sanitizing wipes to assist residents with hand

hygiene before and after meal service.

The hand sanitizing wipe's product label had shown that it contained benzalkonium chloride and no alcohol content. IPAC Lead and the DOC both confirmed that the hand sanitizing wipes did not contain any alcohol, and the DOC stated that they were "comparable wipes" that were purchased by the home's Procurement and Storage Supervisor as they were unable to obtain alcohol-based wipes. The inspector informed IPAC Lead and the DOC that these wipes do not meet the requirements of the IPAC standard.

Failure to ensure that the hand sanitizing wipes included 70-90% ABHR when assisting residents with hand hygiene prior to meal service increased the risk of infection transmission.

Sources: Observations of a meal service; product label of the hand sanitizing wipes; interviews with IPAC Lead, DOC and other staff.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9)

s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection

(2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored.

IPAC Standard for Long-Term Care Homes (revised September 2023), s. 3.1 (b) states the licensee shall ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary
i) The home was in outbreak during an identified period. The home required staff to monitor symptoms indicating the presence of infections on the unit for the affected residents.

The public health line listing identified the onset of first symptoms for a resident was on an identified date. The resident was placed on additional precautions accordingly. Record review of the resident's progress notes showed that symptoms indicating the presence of infections were not documented every shift.

ii) The home was in outbreak during an identified period. The public health line listing identified the onset of first symptoms for two residents was on an identified date. Both residents were placed on additional precautions accordingly. Record review of the residents' progress notes showed that symptoms indicating the presence of infections were not documented every shift.

The DOC and IPAC Lead both indicated that symptoms indicating the presence of infections should have been monitored every shift and documented in the residents'

progress notes. The DOC stated that the home process was to document the symptoms on day and evening shifts only. The inspector informed the DOC and the IPAC Lead that the legislative requirements was to monitor and document on every shift.

IPAC Lead and the DOC both acknowledged that there were missing monitoring documentation for identified residents.

There was moderate risk when the home did not document symptoms indicating the presence of infections every shift.

Sources: CIS #2937-000028-23 and CIS #2937-000031-23, review of three resident's progress notes, review of the public health line listing; interview with IPAC Lead and the DOC

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WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed about an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary

The home went into an outbreak as declared by the Public Health Unit (PHU) on December 27, 2023. The Critical Incident Report (CIS) indicated the outbreak was declared on December 27, 2023, however the report was first submitted to the Ministry of Long-Term Care on December 28, 2023.

The DOC acknowledged that the outbreak was declared on December 27, 2023, and was not immediately reported to the Ministry of Long-Term Care.

There was low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: Critical Incident Report #2937-000034-23, interview with DOC and IPAC Lead.

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WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)

s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact.

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary

A CIS report was submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023, indicated that for critical incidents reported immediately outside of business hours, to call the Service Ontario After-Hours Line.

The DOC confirmed that the home submitted a critical incident report but did not call the Service Ontario After-Hours Line.

Sources: CIS #2937-000031-23; MLTC Reporting Requirements - reference sheet; and interview with DOC.

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