Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ministère des Soins de longue durée
Division des foyers de soins de longue duree
Inspection de soins de longue durée

Order of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Tammy Szymanowski
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	#011445-21, 014871-21
Original Inspection #:	2021_766500_0027
Licensee:	Ukrainian Home for the Aged
LTC Home:	Ivan Franko Home 767 Royal York Road, Toronto, ON M8Y 2T3
Name of Administrator:	Olha Vovnysh

Background:

Ministry of Long-Term Care (MLTC) Inspectors #500 and #704757 conducted a critical incident system inspection at Ivan Franko Home (the Home) on October 19, 20, 21, 22, 25, and 26, 2021. Intake logs (#011445-21, 014871-21) were inspected during the inspection.

The Inspectors determined that the Licensee, Ukrainian Home for the Aged (the Licensee), failed to comply with s. 5 and s. 6(7) of the *Long-Term Care Homes Act, 2007* (LTCHA).
The Inspectors issued compliance orders (CO #001 and CO #002) under s. 153 of the LTCHA for the non-compliance findings.

Following a review of CO #001 and CO #002 by the Director, CO #001 and CO #002 have both been substituted with the Director's Order below.

Order:	CO #001

To: **Ukrainian Home for the Aged**, you are hereby required to comply with the following order by the date set out below:

Pursuant to:

The Director is issuing the following compliance order (s. 153(1)(a)) after finding that the Licensee failed to comply with subsection 19(1) under the *Long-Term Care Homes Act (*LTCHA*)*:

Duty to Protect
19 (1) The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

O. Reg. 79/10

"Abuse" — definition
2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

…

"physical abuse" means, subject to subsection (2),

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;

Order:

The licensee must be compliant with s. 19(1) of the LTCHA and ensure that resident #002 and all residents are protected from physical abuse by resident #003.

Specifically, the licensee must ensure that:

1. One-to-one (1:1) constant supervision is provided to resident #003 for as long as the

resident continues to demonstrate responsive behaviours that place other residents at risk for physical abuse and harm by resident #003.

2. The home's internal multidisciplinary team re-assess resident #003 to evaluate the effectiveness of interventions and consider alternative approaches, including mobility devices to ensure that the risks of maintaining the resident's independent mobility are measured along with managing resident safety in the prevention of abuse.
3. The home continues to work with external partners to develop, implement and evaluate ongoing strategies to manage resident #003's behaviours.

This order must be complied with by: January 28, 2022

Grounds:

The licensee failed to protect resident #002 and other residents from physical abuse by resident #003.

Resident #003 had responsive behaviours towards co-residents and staff that escalated on some days, especially in the evening. Resident #003 had cognitive impairment and behavioural triggers were identified.

There were several behavioural incidents over a three-month period involving resident #003 in which they physically threatened to harm co-residents and staff. Following two separate incidents involving resident #003, both resident #007 and resident #004 were frightened because of the resident's physical and threatening behaviour.

A recommendation was made by Behavioural Supports Ontario (BSO) to implement 1:1 supervision for resident #003. Staff stated the Home utilized certain staff to provide 1:1 supervision and recreation staff to supervise resident #003. RN #101 and PSW #110 stated that the resident did not have 1:1 supervision all of the time.

A staff member heard resident #003 yelling from the television room. Staff approached the room and found resident #003 standing near other residents physically threatening them and resident #002 crying. Resident #003 demonstrated specific behaviour that caused injury to resident #002 who was screaming, started to cry, and had pain as a result of the incident. Resident #002 was taken to their room, they continued crying and stated that they were afraid of resident #003 and afraid to be in their room since resident #003's room was near by. Resident #003 was sent to hospital. The Home had scheduled 1:1 supervision for resident #003 however, the staff member left the resident alone for a period of time to use the washroom, at which time the incident occurred. The DOC stated that the process was if a staff member had to use the washroom, they had to ask someone to cover for them so that close monitoring of the resident would be constant.

Resident #003's plan of care identified sundowning as a focus and behaviour/progress notes

indicated that resident #003's behaviours escalated especially in the evening/night. Additionally, staff, including the DOC, stated that the resident was unpredictable with their behaviours. Resident #003 had 1:1 supervision scheduled during the day, however, an incident with resident #007 occurred in the evening. Despite the licensee's awareness that resident #003 had unpredictable behaviour that escalated in the evening/night, 1:1 supervision was only provided for 8 hours of the day and it was predominantly provided during day hours. During a specific time period, 1:1 supervision was scheduled for 8 hours during the daytime 28 out of 33 days. It was not until after the incident that 1:1 supervision was scheduled 24/7 for the resident.

On October 25, 2021, 1137 hours, PSW #100 who was assigned 1:1 for resident #003 was observed by the Inspector in the television room while resident #003 was in their room. The PSW stated that they were responsible to monitor the resident closely, however, the resident was sleeping and that is why the PSW was not monitoring the resident. The Inspector proceeded to the resident's room where the resident was awake along with their roommate.

The licensee was aware however, that resident #003 was physically threatening toward co-residents, on one occasion, had struck a PSW and several times when the resident threatened co-residents in which staff had to intervene. Despite this awareness, the Home did not reassess resident #003 in order to consider different approaches so that the risks of maintaining the resident's independence while managing the risk to protect residents from resident #003 were assessed.

The licensee failed to ensure that the home protected resident #002 and other residents from abuse by resident #003.

Main sources: resident #003 's plan of care and clinical records, interviews with PSWs, registered staff, BSO lead, and DOC.

An order was made by taking the following factors into account:

Severity of non-compliance: There was actual risk of harm to residents and actual harm to resident #002 by the Licensee's non-compliance with s. 19(1) and when failing to provide 1:1 supervision of resident #003 and the lack of assessment to consider different approaches.

Scope of non-compliance: The scope of the non-compliance was isolated because only a few residents, and one in particular, were affected by the non-compliance.

Licensee's compliance history: The licensee had previous findings of non-compliance related to different requirements of the LTCHA in the last 36 months.

This order must be complied with by:	January 28, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process.

Issued on the 13 day of January 2022	
Signature of Director:	TSzymanowski
Name of Director:	**Tammy Szymanowski**