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: November 3, 2023	
Inspection Number: 2023-1494-0002	
Inspection Type: Complaint	
Licensee: Ukrainian Home for the Aged	
Long Term Care Home and City: Ivan Franko Home (Etobicoke), Toronto	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2023.11.16 11:28:35 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25, 26, 27, 28, and 29, 2023

The following intake(s) were inspected:

- Complaint Intake #00096420 related to improper care.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Summary and Rationale
A complaint was submitted to the Director on an identified date, regarding improper care and transferring of a resident.

The resident sustained several injuries over an identified period of time and the staff did not refer the resident to the Physiotherapist (PT) except on one occasion.

A Registered Nurse (RN) indicated that they did not send a referral to the PT for the resident when they experienced significant injuries and confirmed that the policy was not followed.

The PT confirmed that they did not get any referrals for the resident for approximately one year.

Failure to collaborate in assessing the resident's care needs placed them at risk for not receiving the appropriate care based on their individual needs.

Sources: Resident #001 observations, resident #001's electronic health records and paper chart, Skin and Wound Care Program Policy #NM-I-037 last revised April 2022, skin and wound binder 2023, interviews with RPN #106, the ADOC #101 and other relevant staff.
[698]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward to the Director a written complaint that it received, concerning the care of a resident.

Summary and Rationale
A complaint was submitted to the Director on an identified date, regarding a resident.

A written complaint dated four months prior, was received by the licensee, concerning the care of the resident.

The Assistant Director of Care (ADOC) confirmed that they received the complaint and stated that they were aware of the requirements regarding reporting matters immediately to the Director. They acknowledged that there was a complaints process in place, but the process was not followed.

Failure to report complaints to the Director in a timely manner did not place the resident at risk.

Sources: Review of the Critical Incident and Complaint Binders 2022-2023, and the home's Complaint Policy #ADM-A-005, last revised July 2023, interview with the ADOC #101 and other relevant staff. [698]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated.

Summary and Rationale
On an identified date, a complaint was submitted to the licensee regarding improper care of a resident.

The resident sustained injuries over an identified period of time and the licensee did not investigate as set out in the legislation.

The licensee had no documentation of the complaint investigation.

ADOC acknowledged that they received the complaint regarding the resident. However, an investigation was not conducted by the home.

Failure to investigate complaints related to the resident's care, placed the resident at risk for compromised care.

Sources: Resident #001 electronic health records, the home's Complaint policy #ADM-A-005 last revised in July 2023, complaints binder 2022-2023, interviews with ADOC #101 and other relevant staff.
[698]