Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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5700, rue Yonge 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2019	2019_804600_0015	012803-19	Critical Incident System

Licensee/Titulaire de permis

St. Demetrius (Ukrainian Catholic) Development Corporation
60 Richview Road ETOBICOKE ON M9A 5E4

Long-Term Care Home/Foyer de soins de longue durée

Ukrainian Canadian Care Centre
60 Richview Road ETOBICOKE ON M9A 5E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 10, 12, 15, 2019.

The following inspection for Critical Incident System (CIS) report #2809-000009-19, intake # 012803-19, regarding injury for which a resident was taken to hospital and resulted in a significant change in the resident’s condition.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurse (RN) - Senior Clinical Team Leader, Nurse in Charge (NC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Physiotherapist (PT).

During the course of the inspection, the inspector conducted observation of staff and resident interactions and the provision of care, reviewed resident's health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report was submitted by the home on an identified date, related to an incident that resulted in a significant change in the resident’s condition. A review of the CIS indicated that on an identified date resident #001 was referred to Physiotherapist (PT) for assessment of the significant change. The CIS was amended by the home after the home did an internal investigation. A review of the amended CIS report indicated that on an identified date a Personal Support Worker (PSW) reported to a Registered Practical Nurse (RPN) that resident #001 had a change on an identified body part. A team assessed the resident and sent them for further assessment. In the hospital the resident was diagnosed with identified medical condition. The RPN initiated the CIS considering a cause of the injury to be an identified procedure that the resident had the night before. Also, in the CIS report, a PSW assigned to the resident stated that during care on evening of the identified date, the resident's daughter was providing care to the resident alone.

A review of resident #001’s progress notes indicated that on an identified date, PSW #101 reported to RPN #100 that resident #001’s identified body part had some changes. The RPN and the interdisciplinary team assessed the resident and the physician ordered transfer of the resident for further assessment. The resident underwent an identified procedure with ordered treatment.

A review of resident #001’s discharge summary on an identified date, indicated that the resident was diagnosed with a medical condition on an identified body part. The history of the resident’s health status in the summary revealed that the resident had previous procedure and had treatment provided on two different body parts. Further the summary indicated that the resident’s identified condition had deteriorated.

A review of the home’s investigation notes indicated that on the evening of the identified date, the resident was cared by a Substitute Decision Maker (SDM) and assisted by PSW #108 for part of the care. Further the investigation notes indicated that as per SDM request, the resident was to have an identified procedure done for further diagnostic assessment for follow up analysis of a changed status. Staff who was present during the identified procedure stated they did not experience any problem with the resident during the process, and no signs of discomfort were identified. The statement of the day shift PSW#101 and RPN #100 in the investigation record indicated that they observed the resident that morning, fed them and administered morning treatment, but did not observe any signs of pain or discomfort.

In their interviews, PSWs #104 and #110 and RN #111 involved in the process of the identified procedure, confirmed their statement that they did not observe any discomfort or pain on resident #001 during and post procedure except expected signs of discomfort during this type of procedure with elderly persons. All staff also stated the resident slept the rest of the night. The RN further stated when they changed the resident's identified item that morning, no signs of pain or discomfort were identified.

The statements of the day shift PSW #101 and RPN #100 in the interview indicated that they observed the resident that morning, fed them and administered morning treatment, but did not observe any signs of pain or discomfort. The day PSW stated only when they uncovered the resident to assist them with morning care, they noted the changes on the resident body part. Immediately they called the day RPN to assess the resident.

A review of the resident's Minimum Data Set (MDS) assessment record on a specific day, physiotherapy (PT) assessment and resident #001's plan of care indicated that the resident had an identified medical condition and identified physical status on identified body parts. The resident needed identified assistance by two staff for identified activities of daily living.

An interview with PT, RN #107, RPN #100, PSWs #101 and #108 confirmed that resident #001 had an identified condition. They stated that the plan of care indicated that the resident needed identified assistance by staff for all ADLs and two staff assistance by assistive device for identified activity. Furthermore RN #107, Senior Clinical Team leader confirmed that when a resident needs total assistance for identified activity using assistive device two staff members must complete the process of activity, and a family member does not count as a second person for activity.

In an interview, PSW #108 stated that on the evening of an identified date, when assisting resident #001 from one position to another using assistive device, the PSW did not have assistance from a second staff member. They assisted the resident with a family member present and assisting. Further, the PSW stated that the family member took the resident to the identified location and provided care alone. The PSW also stated that the family member took the resident back to the room and then called the PSW to assist the resident from one position to another with assistive device. In the interview, the PSW confirmed that the resident needed two staff assistance with identified activity with assistive device and acknowledged that they did not follow the resident's plan of care which guided them to have the second staff to assist but rather performed the assistance with family member only. The PSW also acknowledged that they did not follow the

resident's plan of care for identified activity of daily living of resident #001 when they did not provide the activity to the resident with another staff but acceded to the family member to bath resident alone.

A review of the video footage provided from the home from camera located in the hallway in front of room #209 where the resident resided, confirmed the statement of the PSW.

In an interview, Director of Care (DOC) indicated that the family members request was to provide every identified activity to the resident and staff was trying to accommodate the family. However, the DOC acknowledged that PSW #108 had not followed resident #001's plan of care when assisting resident #001 alone using assistive device and a family member as a second person. The DOC also acknowledged that PSW #108 did not follow the resident's plan of care for identified activity of resident #001 when they did not provide the activity to the resident with another staff but assented to the family member to bathe resident #001 alone. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 21st day of August, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2019_804600_0015
Log No. / No de registre :	012803-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 2, 2019
Licensee / Titulaire de permis :	St. Demetrius (Ukrainian Catholic) Development Corporation 60 Richview Road, ETOBICOKE, ON, M9A-5E4
LTC Home / Foyer de SLD :	Ukrainian Canadian Care Centre 60 Richview Road, ETOBICOKE, ON, M9A-5E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Irena Dounets

To St. Demetrius (Ukrainian Catholic) Development Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (7).

Specifically the licensee must:
1) Ensure that for resident #001 and any other resident requiring assistance of two staff members during care, receive care as specified in the plan of care;
2) Develop an auditing system in the home to ensure staff are assisting with two staff members as specified in the plan of care; and
3) Maintain a written record of audits conducted in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome of the audit, and any actions taken.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report was submitted by the home on an identified date, related to an incident that resulted in a significant change in the resident's condition. A review of the CIS indicated that on an identified date resident #001 was referred to Physiotherapist (PT) for assessment of the significant change. The CIS was amended by the home after the home did an internal investigation. A review of the amended CIS report indicated that on an identified date a Personal Support Worker (PSW) reported to a Registered Practical Nurse (RPN) that resident #001 had a change on an identified body part. A team assessed the resident and sent them for further assessment. In the hospital the resident was diagnosed with identified medical condition. The RPN initiated the CIS considering a cause of the injury to be an identified procedure

that the resident had the night before. Also, in the CIS report, a PSW assigned to the resident stated that during care on evening of the identified date, the resident's daughter was providing care to the resident alone.

A review of resident #001's progress notes indicated that on an identified date, PSW #101 reported to RPN #100 that resident #001's identified body part had some changes. The RPN and the interdisciplinary team assessed the resident and the physician ordered transfer of the resident for further assessment. The resident underwent an identified procedure with ordered treatment.

A review of resident #001's discharge summary on an identified date, indicated that the resident was diagnosed with a medical condition on an identified body part. The history of the resident's health status in the summary revealed that the resident had previous procedure and had treatment provided on two different body parts. Further the summary indicated that the resident's identified condition had deteriorated.

A review of the home's investigation notes indicated that on the evening of the identified date, the resident was cared by a Substitute Decision Maker (SDM) and assisted by PSW #108 for part of the care. Further the investigation notes indicated that as per SDM request, the resident was to have an identified procedure done for further diagnostic assessment for follow up analysis of a changed status. Staff who was present during the identified procedure stated they did not experience any problem with the resident during the process, and no signs of discomfort were identified. The statement of the day shift PSW#101 and RPN #100 in the investigation record indicated that they observed the resident that morning, fed them and administered morning treatment, but did not observe any signs of pain or discomfort.

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The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was a level 1 as it applied to one of three residents. The home had a level 3 compliance history as there were 1 or more related non-compliance issued in the last 36 months that included:
Voluntary Plan of Correction (VPC) issued:
October 18, 2018 (2018_526645_0011),
January 30, 2017 (2016_334565_0012).
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of August, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Gordana Krstevska

Service Area Office / Bureau régional de services : Toronto Service Area Office