Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2021	2021_846665_0005	017712-20, 011221-21	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

JOY IERACI (665)

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): October 13, 14, 15 and 18, 2021.

The following intakes were completed in this critical incident system (CIS) inspection:
- Log #017712-20, CIS #2809-000005-20 and;
- Log #011221-21, CIS #2809-000004-21 both were related to falls.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Senior Clinical Team Leader (TL), Infection Prevention and Control Registered Nurse (IPAC RN), IPAC Lead, Falls Lead, Registered Nurses (RNs), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Houskeeping Aide (HA) and PSW Students.

During the course of the inspection, the inspector toured the home, conducted resident observations, reviewed clinical records and pertinent policies.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post-fall assessment had been conducted for resident #002.

Resident #002 was assessed to be at risk for falls. The resident had two falls in a month, and had sustained a significant change in health status after the initial fall. A post-fall assessment was not completed on the second fall.

Interviews with Falls Lead #112 and RN #109 verified that a post-fall assessment had to be completed 24 hours after each fall. Falls Lead #112 confirmed that a post-fall assessment was not completed on the second fall.

Sources: Resident #002's Post-fall assessments, Fall Risk Assessments, interviews with Falls Lead #112, RN #109 and others. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW students #105 and #107, Housekeeping Aide #104, PSW #108 and RPN #106 participated in the implementation of the infection prevention and control program related to the use of personal protective equipment (PPE).

The home has a policy on COVID-19 Best Practices which directed all staff to wear a medical mask and face shield at all times when in resident home areas. Medical masks should not be removed except when a staff member is on break and is eating or drinking. The home follows Public Health Ontario's recommended steps for donning PPE. As per step four related to donning protective eyewear, it stated that face shields should fit over the brow of the individual.

During observations in resident home areas on October 13 and 15, 2021, the following were observed:
- PSW Student #105, Housekeeper #104 and PSW #108 - face shields were worn above their heads;
- RPN #106 - not wearing a mask and visor in the nursing station with two other staff present. Their combination mask/visor was hanging on their right ear and;
- PSW Student #107 - wearing two medical masks. The second mask was the combination mask/visor, and the visor portion was below the PSW student's brow.

Interviews with the staff and student #105 acknowledged that they did not wear the face shield and/or mask appropriately.

Interviews with IPAC RN #102 and IPAC Lead #103 confirmed it is the home's policy that all staff, students and volunteers wear a medical mask and face shield at all times when in resident home areas. The home does not allow any staff and students to wear two medical masks, and face shields must not be lifted above the head when worn. They verified that the staff were not compliant with the home's IPAC program.

Sources: October 13 and 15, 2021 observations; record review of COVID-19 Best Practices, Zero Tolerance Protocol Booklet for all Staff, Appendix A, Best Practices #ADM-IC-15-7 policy; and interviews with PSW students #105 and #107, Housekeeper #104, PSW #108, RPN #106, IPAC Nurse #102 and IPAC Practitioner #103. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than three business days after the occurrence of the incident, where the licensee determined the injury to resident #001 had resulted in a significant change in their health condition.

Resident #001 had a fall and was transferred to hospital the following day. The critical incident report documented it was an incident that caused injury to resident #001, which resulted in a significant change in the resident's health status.

The critical incident report was submitted to the Director seven business days after the incident. ED #100 acknowledged the critical incident was not reported within three business days of the incident.

Sources: Critical Incident Report #2809-000005-20, progress notes and interview with ED #100. [s. 107. (3.1)]

Issued on this 22nd day of October, 2021

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

Original report signed by the inspector.