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: March 28, 2023

Inspection Number: 2023-1299-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation

Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Nira Khemraj (741716)	Niranjani Khemraj Digitally signed by Niranjani Khemraj Date: 2023.03.28 15:54:13 -04'00'

Additional Inspector(s)
Adelfa Robles (723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17, 20, 21, 22, 23, 24, 2023

The following intakes were inspected:

- Intake: #00020532 - Complaint regarding staff to resident abuse, neglect, continence care and care plan.
- Intake: #00021095- Complaint regarding potential staff to resident abuse, care plan and nursing and personal services.
- Intake: #00022080- [CI: 2809-000006-23] Fall of resident resulting in injury.

The following intakes were completed:

- Intake: #00017315-[CI: 2809-000001-23] Unwitnessed fall of resident resulting in injury.
- Intake: #00021754-[CI: 2809-000005-23] Fall of resident resulting in injury.

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

Resident Care and Support Services
Medication Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (9) 1.

The home failed to ensure that a medication was documented when provided as set out in the plan of care for resident #002.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint regarding multiple care concerns for resident #002. As per the complainant, they wanted resident #002 to use a prescribed medication to manage one of their responsive behaviour.

Resident #002 had the prescribed medication ordered to be used on an as needed basis since admission as indicated in Point Click Care (PCC). The Electronic Medication Administration Record (eMAR) indicated that the prescribed medication was not used since admission. The Home's policy indicated that all administered medications ordered on an as needed basis were to be documented in the eMAR including the time, reason for medication and effect.

An Interview with Registered Practical Nurse (RPN) #103 confirmed that resident #002 was administered the medication but it was not documented in eMAR. RPN #103, Registered Nurse (RN) #109 and Director of Care (DOC) all stated that registered staff were expected to document administered medications ordered on an as needed basis in eMAR.

There was a risk and potential injury for resident #002 when administered medication was not documented as set out in the plan of care as it may result in medication errors and poor resident outcomes.

Sources: Resident #002's eMAR and physician orders, home's policy on Medication Administration, interviews with RPN #103, RN #109 and DOC.
[723]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report to the Director the suspicion of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Rationale and Summary
The MLTC received a complaint regarding multiple care concerns for resident #001. As per the complainant, resident #001 reported incidents of alleged abuse from staff to management and they were not satisfied with the actions taken by the home to resolve.

Through review of records, it was identified that resident #001 documented two alleged incidents of abuse that occurred on identified dates. Senior clinical team lead #102, acknowledged being aware of the documented incidents by the resident. Resident #001 acknowledged that they did not bring the incidents to management's attention immediately, but they were aware of the incidents.

Senior clinical team lead #102 confirmed being aware of both incidents and that they were investigated, and actions were taken by the home for one of the incidents where abuse was confirmed. For both documented incidents, the Director was not reported when there was a suspicion of abuse that resulted in a risk of harm to this resident.

Sources: Review of resident #001 documentation, Interviews with resident #001 and senior clinical team lead #102.
[741716]