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
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Original Public Report

Report Issue Date: March 28, 2024
Inspection Number: 2024-1299-0002
Inspection Type: Proactive Compliance Inspection
Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation
Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2024.03.28 14:00:30 -04'00'

Additional Inspector(s)
Carole Ma (741725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 14, 15, 18-22, 25 and 26, 2024

The following intake(s) were inspected:

- Intake: #00110826 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Quality Improvement
Pain Management

Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 351 (2) 1.
Protection of privacy in reports
s. 351 (2) Where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only the following shall be posted, given or published, as the case may be: 1. Where there is a finding of non-compliance, a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding.

The licensee has failed to ensure that where an inspection report mentioned in O. Reg. 246/22, section 351 clause (1) (a), (c) or (d) contained personal information or private health information, only a public version of the report, that had been edited by an inspector, was posted.

Rationale and Summary

On March 14, 2024, five Ministry of Long-Term Care (MLTC) licensee reports (LR) detailing non-compliances, from inspections were posted on the long-term care home's (LTCH) public information board near the reception desk. The LRs were accessible to residents and visitors, and contained residents' personal information and private health information.

On March 18, 2024, the Executive Director (ED) acknowledged the LRs were posted in the home and replaced them with the public versions.

While no one was observed reading the LRs during the initial observation, the non-compliance posed a low risk to resident privacy.

Sources: Observations; five LRs and; interview with ED. [741725]

Date Remedy Implemented: March 18, 2024

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

The licensee has failed to ensure the call bell cord in a shared bathroom was easily accessible to a resident.

Rationale and Summary

The call bell cord in a shared bathroom was found to be shortened. The long tail of the cord had been separated and wrapped around the grab bar beside the toilet.

A Personal Support Worker (PSW) indicated that a resident used the bathroom independently. The PSW and a Registered Practical Nurse (RPN) did not know how long the cord had been shortened.

The resident was assessed to be at risk for falls and had a history of falls.

The ED acknowledged that the call bell cord in the shared bathroom was not easily accessible.

This non-compliance placed the resident at risk of not being able to call for assistance when in the bathroom.

Sources: Call bell observation; review of a resident's clinical records; and interviews with a PSW, RPN and ED. [741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene (HH) which included the four moments of HH, (before and after resident/resident environment contact) as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

During a meal service on one resident home area's (RHA) dining room, a Recreation Aide (RA) was wearing a surgical mask that slipped below their nose multiple times. While providing meal assistance to a resident, the RA raised their mask multiple times and did not conduct HH before contacting the resident/resident environment. The RA acknowledged they could have transferred infectious agents to the resident.

Additionally, a Student provided meal assistance to another resident and multiple times, would turn and assist a co-resident with their meal. The Student did not conduct any HH when care was provided between the two residents, and acknowledged they should have.

The IPAC Lead confirmed that staff did not conduct HH as per the four moments, which placed the residents at risk for infection transmission.

The residents were at risk of infection transmission when HH was not conducted by staff.

Sources: Dining observations in one RHA; and interviews with a RA, Student and IPAC lead. [741725]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information: 5. A written record of, i. the date the survey required under section 43 of the Act was taken during the fiscal year.

The licensee has failed to ensure that the continuous quality improvement (CQI) report contained a written record of the date the Resident and Family/Caregiver Experience Survey was taken during the fiscal year.

Rationale and Summary

The CQI report published on the home's website dated March 30, 2023, did not have the date the Family/Caregiver Experience Survey was taken, and was acknowledged by the Manager of Quality.

There was no impact to residents, however the public did not have the required information in the home's CQI plan.

Sources: Review of Quality Improvement Plan (QIP), Narrative for Health Care Organizations in Ontario dated March 30, 2023; and interview with the Manager of Quality. [665]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information: 5. A written record of, iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the CQI report contained a written record of how, and the dates when, the results of the Resident and Family/Caregiver Experience Survey were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary

The CQI report did not include how and the dates when the home communicated the Survey results to residents and their families, the Residents' Council, Family Council and members of the staff of the home, which was acknowledged by the Manager of Quality.

There was no impact to residents, however the public did not have the required information in the home's CQI plan.

Sources: Review of QIP, Narrative for Health Care Organizations in Ontario dated March 30, 2023; and interview with the Manager of Quality. [665]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iii.

Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information: 6. A written record of, iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii.

The licensee has failed to ensure that the CQI report contained a written record of the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii.

Rationale and Summary

The CQI report, did not have information on the role of the Residents' Council and Family Council, in the home's CQI initiative, which was acknowledged by the Manager of Quality.

There was no impact to residents, however the public did not have the required information in the home's CQI plan.

Sources: Review of QIP, Narrative for Health Care Organizations in Ontario dated March 30, 2023; and interview with the Manager of Quality. [665]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.

Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information: 6. A written record of, v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the CQI report contained a written record of how, and the dates when actions taken were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary

The CQI report did not include how the home communicated to residents and their families, the Residents' Council, Family Council and members of the staff of the home of how and the dates when actions were taken, which was acknowledged by the Manager of Quality.

There was no impact to residents, however the public did not have the required information in the home's CQI plan.

Sources: Review of QIP, Narrative for Health Care Organizations in Ontario dated March 30, 2023; and interview with the Manager of Quality. [665]

WRITTEN NOTIFICATION: ORIENTATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,

(a) hand hygiene;
(b) modes of infection transmission;

(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;
(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that a registered staff received IPAC training prior to starting their first shift.

Rationale and Summary

A registered staff was on a leave of absence for an extended period and returned to work. They indicated they did not receive any IPAC orientation or training before returning to their responsibilities, which was confirmed by the IPAC Lead.

This non-compliance placed residents and staff at risk for infection exposure and transmission.

Sources: Review of emails from the IPAC Lead; and interviews with a registered staff and IPAC Lead. [741725]