Public Report

Report Issue Date: September 16, 2025
Inspection Number: 2025-1299-0006
Inspection Type: Critical Incident
Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation
Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11 to 12 and 15 to 16, 2025

The following intake(s) were inspected:

- Intake: #00151780 / Critical Incident (CI) #2809-000016-25 - related to injury of an unknown cause
- Intake: #00154356 / 2809-000018-25 - related to the Outbreak of a communicable disease
- Intake: #00155508 / CI #2809-000020-25 related to falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
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 (7)
Plan of care

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

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.

The licensee has failed to ensure that the care set out in multiple residents plan of care were provided to the residents as specified in the plan.

a) The resident's plan of care indicated that they required to have a falls injury prevention intervention in place. The resident was observed without the intervention in place. A staff verified that the resident was required to have the intervention.

Sources: Resident's clinical records, observation and interview with a staff.

b) The resident's plan of care indicated that they required an attachment to be applied to their assistive device. The resident was observed being assisted with transportation by staff in their assistive device without the attachment being applied. Multiple staff acknowledged that the attachment should have been applied to the resident's assistive device.

Sources: Resident's clinical records; observation and Interviews with multiple staff.