

**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

## Public Report

<b>Report Issue Date:</b> November 5, 2025
<b>Inspection Number:</b> 2025-1299-0007
<b>Inspection Type:</b> Complaint Critical Incident
<b>Licensee:</b> St. Demetrius (Ukrainian Catholic) Development Corporation
<b>Long Term Care Home and City:</b> Ukrainian Canadian Care Centre, Etobicoke

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, 2025, and November 3-5, 2025.

The following intake(s) were inspected in the Complaints Inspection:

- Intake: #00157379 - related to an injury of unknown cause, and neglect related to care
- Intake: #00157671 - related to improper care, and neglect related to care

The following intake(s) were inspected in the Critical Incident (CI) Inspection:

- Intake: #00154091 - CI: 2809-000017-25 - related to improper care, and skin and wound prevention and management
- Intake: #00155424 - CI: 2809-000019-25 - related to prevention of physical abuse and neglect
- Intake: #00158404 - CI: 2809-000021-25 - fall prevention and management

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

- Resident Care and Support Services
- Falls Prevention and Management

## INSPECTION RESULTS

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## 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: FLTCA, 2021, s. 6 (9) 1.**

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident was documented. Documentation indicated that a resident was provided assistance with an activity of daily living (ADL) once by a Personal Support Worker (PSW). The PSW indicated that they provided assistance multiple times on that shift, but did not document it. The PSW documented the assistance they provided to the resident at a later date.

**Sources:** Review of the resident's clinical records; and interview with the PSW.

Date Remedy Implemented: November 4, 2025

## WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (4) (a)**

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure staff involved in a resident's care collaborated with each other.

i) The resident sustained an injury while being assisted with an ADL. Two PSWs noticed

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the resident had signs of an injury and did not report the incident to the registered nursing staff for monitoring and assessment.

ii) The resident informed two PSWs that they were injured during assistance with an ADL. The PSWs did not report the incident to the registered nursing staff for monitoring and assessment. The resident presented with an injury on the following shift.

The Senior Clinical Team Leader confirmed that the PSWs should have informed the registered nursing staff about each incident.

**Sources:** Resident's clinical records, home's investigation notes; and interview with the Senior Clinical Team Leader.

## WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 40**

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW used safe positioning techniques when assisting a resident who required a specific level of assistance with an ADL. When the PSW assisted the resident with an ADL without providing the required level of assistance, the resident sustained an injury.

**Sources:** Resident's clinical records, home's investigation notes, home's policy "RCS 6-5-5 Minimal Lift Program Procedures for Lifts and Transfers; and interview with the Senior Clinical Team Leader.

## WRITTEN NOTIFICATION: Dealing With Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**

Dealing with complaints

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s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a response was provided to the complainant within 10 business days of the receipt of the complaint. The long-term care home received a written complaint regarding the care of a resident. No response was provided to the complainant within 10 business days of the receipt of the complaint.

**Sources:** Written complaint; interview with the Director of Care (DOC), Senior Clinical Team Leader, and Manager of Quality, Education and Organizational Development.

## WRITTEN NOTIFICATION: Dealing With Complaints

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

**Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)**

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve a complaint, including the date of the action, time frames for actions to be taken and any follow-up action required. The long-term care home received a written complaint regarding the care of a resident. No documentation record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

**Sources:** Written complaint; interviews with the DOC, Senior Clinical Team Leader, and Manager of Quality, Education and Organizational Development.