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 22, 2023	
Inspection Number: 2023-1494-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Ukrainian Home for the Aged	
Long Term Care Home and City: Ivan Franko Home (Etobicoke), Toronto	
Lead Inspector Fiona Wong (740849)	**Inspector Digital Signature** Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2023.03.22 13:04:36 -04'00'
Additional Inspector(s) Nrupal Patel (000755) was present during this inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7-9,13-15, 2023.

The following intake(s) were inspected:

- Intake: #00020149 - was a complaint related to alleged improper/incompetent care
- Intake: #00020706 - [Critical Incident System #C530-000002-23] - was related to falls prevention and management

The following intake(s) were completed:

- Intake: #00019443 - [Critical Incident System #C530-000001-23] - was related to falls prevention and management

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control (IPAC)
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 (10) (c)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the care set out in the plan has not been effective.

Rationale and Summary
The resident was at risk for falls. The resident's plan of care indicated that a specified intervention was required during toileting.

On a specified date, the specified intervention was followed during toileting. The resident had a fall in the washroom.

A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated that the specified intervention was not effective. The Director of Care (DOC) stated that the plan of care should be reviewed and revised.

There was risk to the resident when the plan of care was not effective to manage their falls risk.

Sources: Interviews with a PSW, an RPN, and the DOC, the resident's clinical records.

[740849]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given

an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
On a specified date, an RPN was notified by PSWs that the resident presented with altered skin integrity. The Medical Doctor (MD) was notified, and assessment was completed with interventions initiated. The SDM was not notified of the resident's condition and the assessments. The SDM was contacted later in the night when the resident's condition worsened.

No documentation was found relating to notifying the SDM of the altered skin integrity and MD recommendations. The RPN confirmed that the SDM was not notified.

The RPN and the DOC indicated that the SDM should have been notified.

There was low risk to the resident as they were assessed with interventions in place when the skin concern was identified.

Sources: Interviews with an RPN, the DOC, and other staff, the resident's clinical records.

[740849]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with post-fall management processes for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to have a written description of the falls program that includes its goals, objectives, procedures and protocols, and must be complied with.

Specifically, staff did not comply with the policy "Fall and Post-Fall Assessment and

Management", dated April 2022, which was included in the licensee's Falls Prevention and Management Program. The policy indicates that the person finding the resident after the fall should not move the resident and report the fall immediately to registered staff.

Rationale and Summary
On a specified date, the resident was found on the floor. Two PSWs transferred the resident before reporting to a registered staff.

A PSW stated that depending on the resident's circumstance, they might assist with the transfer before reporting to the registered staff.

Another PSW, an RPN, and the DOC indicated that the resident must not be moved after a fall and must report to registered staff. This was consistent with the home's falls prevention and management policy.

There was risk of worsening an injury when the resident was transferred before they were assessed by a registered staff.

Sources: Interviews with 2 PSWs, an RPN, and the DOC, the resident's clinical records, the home's falls prevention and management policy.

[740849]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
On a specified date, an RPN was notified by PSWs that the resident presented with altered skin

integrity. The Medical Doctor (MD) was notified, and assessment was completed.

The RPN stated that they had conducted a skin assessment for the resident, but the assessment instrument that was specifically designed for skin and wound assessment was not completed.

The RPN and the DOC indicated that the assessment instrument should have been completed when the resident presented with an altered skin integrity. This was consistent with the home's skin and wound care policy.

There was low risk to the resident as they were assessed by the registered staff and MD, and treatment was ordered and provided.

Sources: Interviews with the RPN and the DOC, the resident's clinical records, the home's skin and wound care policy.

[740849]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the additional requirements under the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard) were followed.

Specifically additional requirement 9.1 (b) under the IPAC Standard states that the licensee shall ensure that Additional Precautions are followed in the IPAC Program, including four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environmental contact).

Rationale and Summary
On March 9, 2023, a PSW was inconsistently performing hand hygiene when entering and exiting resident rooms within a COVID-19 outbreak unit. The PSW did not perform hand hygiene after exiting a resident's room that required droplet and contact precautions and

proceeded to assist another resident in the hallway with close contact. The PSW later entered another resident's room without performing hand hygiene and assisted a resident with putting on clothing protector prior to lunch.

The IPAC Lead and the DOC indicated that staff must perform hand hygiene when entering and exiting resident rooms as required by routine practices.

The home's hand hygiene program policy stated that hand hygiene should be done by everyone on entry to a resident's room and leaving a resident's room, even if the resident has not been touched.

Failure to consistently perform hand hygiene during an outbreak increased the risk of infectious disease transmission in the home.

Sources: Inspector #740849's observations, interviews with a PSW, the IPAC Lead and the DOC, the home's hand hygiene policy.

[740849]