

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

Public Report

Report Issue Date: February 20, 2025

Inspection Number: 2025-1494-0001

Inspection Type:Critical Incident

Licensee: Ukrainian Home for the Aged

Long Term Care Home and City: Ivan Franko Home (Etobicoke), Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10, 11, 12, 2025 The inspection occurred offsite on the following date(s): February 19, 2025 The following intake(s) were inspected:

Intake: #00134154 – was related to a disease outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9)

Infection prevention and control program



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- s. 102 (9) The licensee shall ensure that on every shift,
- (a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and
- (b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and the symptoms were recorded and that immediate action was taken to reduce transmission and isolate residents and place them in cohorts as required.

Two residents presented with signs and symptoms of a respiratory infection. The symptoms were not immediately documented, and the residents were not placed on additional precautions once the symptoms started. The residents were later confirmed positive for a respiratory infection.

While the residents presented with symptoms, they were provided care without additional precautions in place.

The home was declared in outbreak with multiple residents affected.

Sources: review of residents' clinical record, home's policies IC-A-046 and IC-A-043, dated May 2024, outbreak management records, interview with registered staff and the Infection Prevention and Control (IPAC) lead.

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