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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
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Original Public Report

Report Issue Date: November 18, 2022

Inspection Number: 2022-1299-0001

Inspection Type:
Critical Incident System

Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation

Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Rodolfo Ramon (704757)	Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2022.11.28 14:11:39 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 28, 31, 2022
November 1-4, 2022
November 7-10, 2022

The following intake(s) were inspected:

- Intake: #00004502-[CI: 2809-000009-22] was related to an unwitnessed fall resulting in injury.
- Intake: #00004734-[CI: 2809-000001-22] was related to an injury to a resident of unknown cause.
- Intake: #00005471-[CI: 2809-000005-21] was related to an unwitnessed fall resulting in injury.
- Intake: #00011317-]CI: 2809-000010-22] was related to an outbreak.

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

-Infection Prevention and Control
-Falls Prevention and Management
-Resident Care and Support Services

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INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

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

Non-compliance with: O.Reg. 246/22, s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance were complied with.

Rationale and Summary

Observations of the home's Infection Prevention and Control (IPAC) practices identified screener #100 did not follow the manufacturer's instructions for use of the rapid antigen test (RAT). The instructions on the RAT kit required the user to wait 15-20 minutes before reading the test result. Screener #100 discarded the specimen 8 minutes after the swab collection.

The DOC acknowledged that the manufacturer's instructions were not followed to ensure accuracy of the test results.

There was actual risk of harm to residents, staff and visitors related to not following the RAT device's instructions as they pertain to the accuracy of the test results and consequently potential spread of an infectious disease.

Sources: IPAC observations, review of Abbott COVID-19 Ag Rapid Test Device's instructions, interviews with screener #100, and the DOC. [704757]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #2 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22 s. 102(2)(b)

The licensee failed to ensure that the infection prevention and control (IPAC) standard issued by the

Director was followed as it relates to hand hygiene practices and ensuring all the hand hygiene agents are at least 70-90% alcohol.

During IPAC observations, the inspector identified multiple 70% alcohol sanitizers to be expired, and alcohol wipes containing 62% alcohol.

The IPAC lead and the DOC acknowledged the home was required to use 70-90% alcohol sanitizers, and that according to the sanitizing product manufacturer, expired sanitizers were less effective. This placed residents at moderate risk of contracting infectious diseases as no products were available in the home that were above 70% alcohol and not expired.

Sources: IPAC observations, Hand hygiene policy ADM-IC-3-1 last reviewed March 2022, and interviews with the DOC and IPAC lead.

[704757]

During IPAC observations in the home, two residents were observed having their hands cleaned with wipes that did not contain alcohol, and one staff was observed having direct contact with multiple residents without performing hand hygiene.

According to the licensee's hand hygiene policy, "hand hygiene should be performed after any direct contact with a resident and before contact with the next resident". The IPAC lead and the DOC verified staff and residents were required to perform hand hygiene with the appropriate hand hygiene agents.

Sources: IPAC observations, Hand hygiene policy ADM-IC-3-1 last reviewed March 2022, and interviews with the DOC and IPAC lead.
[704757]

WRITTEN NOTIFICATION: REPORTING CRITICAL INCIDENTS

NC #3 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22 s. 115(1)(5)

The licensee has failed to ensure the Director was immediately notified of an outbreak of a disease of public health significance.

Rationale and Summary

A CIS report was submitted for an infectious disease outbreak that was declared days after.

The DOC verified on an interview that the Director was not notified immediately through the CIS reporting process or after-hours line.

Sources: CIS report #2809-000010-22, interview with the DOC.
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