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

Original Public Report

Report Issue Date: December 11, 2023	
Inspection Number: 2023-1299-0005	
Inspection Type: Complaint Critical Incident	
Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation	
Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 14-17, 20, 21-23, 2023

The following intakes were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00097227 – [CI:2809-000018-23] related to falls prevention and management
- Intake: #00098784 – [CI:2809-000022-23] related to a disease outbreak.
- Intake: #00099392 – [CI:2809-000023-23/2809-000024-23] related to a resident's care.

The following intake was inspected in the Complaint Inspection:

- Intake: #00099242 related to a resident's care.

The following intakes were completed in the CIS Inspection:

- Intake: #00095221 – [CI:2809-000014-23] related to resident's fall.
- Intake: #00097228 - [CI:2809-000019-23] related to resident's fall

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
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
Duty of licensee to comply with plan
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 the plan of care was provided to resident #002 and resident #003 as specified in their plan.

Rationale and Summary
i) The home submitted a CIS report to the Ministry of Long-Term Care (MLTC)

regarding resident #002's fall that resulted in an injury. The CIS report indicated that a specific fall intervention was not in place at the time of the fall.

Resident #002's plan of care indicated that they were at high risk for fall and required specific fall intervention to be applied.

Personal Support Worker (PSW) acknowledged that resident #002 did not have the specific fall intervention at the time of the fall. Senior Clinical Team Leader (SCTL) acknowledged that care set out in the plan of care related to specific fall intervention was not provided to the resident.

Failure to apply specific fall intervention on resident #002 placed them at an increased risk for injury as a result of a fall.

Sources: CIS, resident #002's care plan, interviews with PSW, SCTL and other staff.

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ii) Resident #003 required to use a specific device during a specific period.

On two occasions, the resident was observed without wearing the specific device. The PSW was present during that period, however they failed to follow the care plan instructions for the application of the device.

PSW acknowledged that the device should have been applied, and that the care plan instructions was not followed. Registered Practical Nurse (RPN) and SCTL, both acknowledged that care set out in the plan of care related to the device application was not provided to resident #003.

Failure to follow resident #003’s care plan instructions for the device application when required placed them at risk for experiencing negative health outcomes.

Sources: Resident #003’s care plan, observation, interviews with PSW, RPN and SCTL.

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iii) A CIS reported that resident #002 incurred an injury as a result of the fall.

According to the resident's care plan, a specific fall intervention device was needed, and staff were to ensure it was working properly.

During the observation, resident #002 was observed having fall intervention device on, however it was not in a working order.

PSW acknowledged that resident #002's fall intervention device was not functioning.

Failure to ensure resident #002’s specific fall intervention device was in a working order as set out in their care plan placed them at an increased risk for fall or further injury.

Sources: Observation, and interview with PSW.

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WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they had immediately forwarded to the Director any written complaint that it received concerning the care of a resident where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

Rationale and Summary
A written complaint was submitted to the home by the resident's Substitute Decision Maker (SDM). The written complaint was not forwarded to the Director as per reporting guidelines.

The home's policy titled "Residents/Family Concern/Complaint Resolution" directed to inform the Ministry of Health and Long-Term Care (MOHLTC) if complainant requests that MOHLTC be notified, or the complaint meets criteria for reporting.

SCTL and Executive Director, both acknowledged that the written complaint was

not reported to the MLTC. The CIS portal indicated that no critical incident has been submitted related to the written complaint.

Sources: Review of CIS portal, home's complaints record 2023, review of Residents/Family Concern/Complaint Resolution policy, ADM-RS-05 last revised June 2023, and interview with SCTL and ED.

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WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that Infection Prevention and Control (IPAC) audits were carried out as per Minister's Directive that applied to the long-term care home.

Specifically, per section 1.1 of the Minister's Directive, the licensee must conduct regular IPAC audits in accordance with the guidance document. The audits were to be completed at least quarterly when not in outbreak, and weekly when in outbreak.

Rationale and Summary
A CIS report was submitted to the Director related to a confirmed outbreak in the home. As per CIS, the home was in a confirmed outbreak status from October 5 to November 2, 2023.

The home's self-assessment IPAC audits revealed that three weekly audits were not completed when the home was in an outbreak from October 5, 2023, to November 2, 2023. IPAC Lead acknowledged that the IPAC self-audits were not completed as per the Minister's Directive.

Failure to ensure that IPAC self-assessments were completed compromised the home's ability to adequately respond to COVID-19 outbreaks.

Sources: Home's IPAC self-audits, CIS, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario last updated November 2023; and interview with IPAC Lead.

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WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that the continence plan of care was implemented for a resident.

Rationale and Summary

The resident's care plan related to continence care indicated that they needed specific staff assistance with the toileting process and received a type of incontinence care routine.

During an observation, staff did not provide the incontinence care routine to the resident as per their continence plan of care.

PSW #112 and PSW #113 both stated that the resident was assisted with the toileting process, however incontinence care routine at a specific time was not completed as mentioned in the resident's plan of care.

Failure to follow the resident's incontinence care routine placed them at risk for not receiving the care they required to promote and manage their bladder and bowel continence.

Sources: Resident's clinical records, observation, interviews with PSW #112, #113 and other staff.

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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 (9) (a)
Infection prevention and control program
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);

The licensee has failed to ensure that symptoms indicating the presence of infection for a resident were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections (HAIs).

Rationale and Summary
A resident had respiratory symptoms and tested positive for an infection.

The home policy titled "Surveillance" last revised in March 2023 directed on every shift, staff to monitor residents for any signs or symptoms of infection, and document the resident's progress and outcomes or any changes to health status in progress notes every shift for the duration of signs and symptoms of infection, or upon completion of antibiotic.

The resident's progress notes indicated that staff failed to monitor and record on every shift when the resident was symptomatic and being treated for an infection.

The RPN verified that when a resident has symptoms of an infection, staff are to monitor them, and document the symptoms in a progress note on every shift. The IPAC Lead reviewed the resident's progress notes and acknowledged staff had not monitored and documented on each shift when the resident had infection.

Failure to monitor the resident's infection placed them at risk for inadequate treatment and delayed recovery.

Sources: Resident's progress notes and care plan, home's policy Surveillance ADM-IC-4-1 last revised March 2023, interviews with RPN and IPAC Lead.

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WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
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:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response provided to the resident's daughter, who made a complaint, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
The home's 2023 complaints record indicated that written complaints were submitted to the home by the resident's SDM concerning the care of the resident.

A review of the licensee's responses to the complainant related to complaints did not include the Ministry's toll-free number for making complaints and its hours of

service, and the contact information for the Patient Ombudsman.

The ED acknowledged that responses provided to the complainant related to the resident's care concerns did not include information about the Ministry's toll-free number for making complaints and its hours of service, and the contact information for the Patient Ombudsman.

Sources: Review of CIS portal, home's complaints record 2023, review of Residents/Family Concern/Complaint Resolution, ADM-RS-05 last revised June 2023, and interviews with SCTL and ED.

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WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.
Dealing with complaints
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:
3. The response provided to a person who made a complaint shall include,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that the written response provided to the resident's SDM, who made a complaint concerning the resident's care, included confirmation that the home had immediately forwarded the complaint to the Director.

Rationale and Summary
The home's 2023 complaints record indicated that written complaints were submitted to the home by the resident's SDM. The responses provided to the complainant for complaints did not include confirmation that the home had immediately forwarded complaints to the Director.

The ED acknowledged that responses provided to the complainant related to the resident's care concerns did not include information on the home's requirement to report it to the Director.

Sources: Review of CIS portal, home's complaints record 2023, review of Residents/Family Concern/Complaint Resolution, ADM-RS-05 last revised June 2023, and interviews with SCTL and ED.

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COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:
1) Revise resident #002's plan of care to specify a location for the resident's specified assistive device to prevent independent ambulation.
2) Review resident #002's plan of care with all PSW and registered staff on the RHA.
3) Maintain documented staff attendance of the above plan of care review, to include, but not limited to: date of review, names of staff attending and person(s) responsible for conducting the review.

Grounds
The licensee has failed to ensure that there was a written plan of care that set out clear directions regarding resident #002's fall prevention strategy.

Rationale and Summary
Resident #002 had a fall while ambulating with their assistive device. Upon assessment, resident #002 complained of pain, and had a change in their health condition. Later they were transferred to hospital and diagnosed with an injury. Resident #002's progress notes indicated when the PSW entered the resident's room, the resident was observed in a specific manner with their assistive device present.

Resident #002's plan of care indicated that they required the staff to position their assistive device away from them but did not specify where the assistive device should be positioned to prevent them from accessing it.

During an observation, the assistive device was placed inside the residents' room at a specified location.

The PSW acknowledged at the time of the fall, resident #002's assistive device was placed at a specified location and was easily accessible for them to use. SCTL

acknowledged that the resident's plan of care did not provide clear directions to staff for the placement of the assistive device.

Failure to provide clear directions for the placement of resident #002's assistive device in the room increased their risk for falls and injury.

Sources: Resident #002's clinical records, CIS, interviews with PSW, SCTL, and other staff.

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This order must be complied with by January 19, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:
(1) Ensure all staff assigned to the second-floor resident home area (RHA) are re-educated on hand hygiene practices in accordance with the home's hand hygiene program.

(2) Audit hand hygiene practices on the second-floor RHA for a period of four weeks on each shift, following the service of this order, to ensure staff follow "four moments of hand hygiene" and support residents with hand hygiene using 70-90% Alcohol-Based Hand Rub (ABHR).
(3) Maintain a record of the education provided, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training.
(4) Maintain a record of the audits, including the date, result of each audit, the staff member who conducted the audit, and the actions taken in response to the audit findings.

Grounds
The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, Sections 9.1 and 10.1, "the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program", including the four moments of hand hygiene and that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR)".

Rationale and Summary
(i) The Activation Aide (AA) assisted residents with hand hygiene using alcohol-free personal care wipes after a recreation activity. Later, during dining service on the second floor, staff were observed using the same alcohol-free personal care wipes to perform residents' hand hygiene prior to serving meals.

The home's policy titled "Hand Hygiene" last revised in March 2022 indicated the hand hygiene program must include use of a 70-90% alcohol-based hand rub.

The IPAC lead acknowledged that the personal care wipes that were provided to

residents after recreation activity and prior to their meals did not contain any alcohol and should not have been used for hand hygiene.

Due to the home not ensuring access to 70-90% ABHR, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents.

Sources: Dining observation, IPAC Standard for LTCH's last revised April 2022, Home's hand hygiene policy # ADM-IC-3-1, last revised March 2023, interviews with IPAC lead and other staff.

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ii) The PSW was observed physically assisting two wheelchair-dependent residents to the dining room for a meal service. PSW did not perform hand hygiene in between resident interactions and prior to initiating feeding for one of the residents.

The home's policy titled "Hand Hygiene" indicated hand hygiene should be performed before feeding a resident and after contact with items considered likely to be contaminated.

The PSW acknowledged that they did not perform hand hygiene before initiating feeding for the resident and in-between assisting residents to the dining room. The IPAC Lead acknowledged that PSW did not implement appropriate hand hygiene practice.

Failure to ensure hand hygiene was performed according to routine practices increased the risk of infectious disease transmission.

Sources: Dining observation, IPAC Standard for LTCH's last revised April 2022, Home's hand hygiene policy # ADM-IC-3-1, last revised March 2023, interviews with PSW and IPAC lead.

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This order must be complied with by January 19, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.