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

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Original Public Report

Report Issue Date: June 20, 2024
Inspection Number: 2024-1299-0003
Inspection Type: Critical Incident
Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation
Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2024.06.20 14:14:40 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24, 27, 29, 30, 31, 2024 and June 3, 4, 2024

The following intake(s) were inspected:

- Intake: #00111754 -[Critical Incident (CI):2809-000004-24] - unknown etiology fracture
- Intake: #00113312 -[CI:2809-000005-24] - Parainfluenza outbreak

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

Pain Management

INSPECTION RESULTS

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: 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 licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary
On May 24, 2024, the inspector found an expired hand sanitizer in use. IPAC Lead

acknowledged that the expired product should have been replaced.

IPAC Lead replaced the expired hand sanitizer on May 27, 2024, when it was brought to their attention.

Due to the home using expired hand sanitizers, there was a risk of infection transmission as they may have been less effective against pathogens.

Sources: Inspector's observations, interview with IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

[704758]

Date Remedy Implemented: May 27, 2024

WRITTEN NOTIFICATION: Plan care

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

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff related to private companion.

Rationale and Summary
A resident had a private companion and their care plan stated that the private

companion was for visitation. The resident was two person total assistance for Activities of Daily Living (ADLs) . The Executive Director (ED) stated that private companions are not considered staff and should not provide any personal care. A Personal Support Worker (PSW)#109, and Registered Nurses (RNs) #104 and #108 stated that the private companion assisted the primary PSW in providing care to the resident and acted as a second staff. Additionally, they stated that the resident's care plan did not provide clear directions related to role of the private companion. ED acknowledged that clear directions related to private companions should have been included in the care plan.

Failure to set out clear directions for private companion's role increased potential risk of the resident being improperly cared for.

Sources: resident's care plan, and interviews with RN #104, #108, PSW and ED.

[704758]

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 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

The licensee has failed to ensure that a PSW collaborated with the Registered staff in the assessment of a resident when they experienced agitation and responsive

behaviours during personal care.

Rationale and Summary
A resident had history of agitation and responsive behaviours during personal care. Their Electronic Medication Administration Records (E-MAR) indicated a pharmacological intervention for agitation. The PSW stated that the resident was agitated and displayed responsive behaviours during direct care but they did not inform the registered staff prior to care. RNs #104, and #108 stated that the PSW did not report resident's agitation and responsive behaviours, therefore they did not administer the pharmacological intervention.

Senior Clinical Team Leader acknowledged that the PSW and Registered staff were expected to collaborate with each other to ensure the pharmacological intervention was implemented as needed to manage the resident's agitation.

Staff failure to collaborate with each other put the resident at risk of not receiving effective treatment to mange their agitation.

Sources: resident's clinical records, and interviews with the PSW, RN #104, #108, and Senior Clinical Team Leader.

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WRITTEN NOTIFICATION: General requirement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and resident response to interventions were documented.

Rationale and Summary
A resident's clinical records revealed that an RN administered pain medication to the resident. RN stated that they assessed the resident for new onset of pain and redness however, they did not document their assessment and actions.

Senior Clinical Team Leader acknowledged that the RN was expected to document their assessment of the resident, as well as interventions implemented.

There was risk to the resident's health and safety when their assessments were not documented, as there were no further actions to monitor the resident and provide appropriate interventions as required.

Sources: resident's clinical records, and interviews with RN and Senior Clinical Team Leader.

[704758]

WRITTEN NOTIFICATION: Pain management

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

Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that strategies to manage pain, including non-pharmacologic interventions were implemented and complied with for a resident.

Rationale and Summary

A resident was observed with a significant injury and was transferred to the hospital. Review of progress notes revealed that the resident experienced pain and was seen weeping and crying. EMAR revealed that no pain medication was administered to the resident. The RN and the RPN stated that they were aware that the resident experienced pain however they did not administer pain medications. Furthermore, they stated that no non-pharmacological interventions were implemented for the resident's pain.

The Senior Clinical Team Lead stated that staff were expected to treat the resident's pain using pharmacological as well as non-pharmacological interventions..

Failure to treat the resident's pain caused the resident unnecessary distress and discomfort.

Sources: resident's clinical records, and interviews with RN, RPN and Senior Clinical Team Lead.

[704758]

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours, and action were taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
A resident had a history of responsive behaviours including physical aggression during care. A PSW, and RNs #104, and #108 stated that the resident exhibited physical aggression daily during care. The Senior Clinical Team Lead/ Behavioral Support Ontario (BSO) Lead verified that the resident's responsive behaviour triggers were not identified, written strategies were not developed to manage their agitation

and physical aggression, and no actions were taken or documented to respond to their needs.

Failure to ensure that for the resident's responsive behaviour triggers were identified, written strategies were developed, and action taken and documented to respond to their needs placed the resident at risk of reoccurrence and escalation of responsive behaviours.

Sources: resident's clinical records, and interviews with PSW, RN #104, #108 and Senior Clinical Team Lead/ BSO Lead.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: hand hygiene,

including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
(i) On May 24, 2024, PSW #106 was observed entering a resident's room to fix the blanket and then exiting their room. The PSW did not perform hand hygiene before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that the staff was required to perform hand hygiene before and after resident/resident environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: inspector's observations, interviews with PSW #106 and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

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Specifically, Section 7.3, "the licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and ensures that audits were performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

Rationale and Summary

(ii) Review of the Long-Term Care Home (LTCH)'s IPAC audits revealed that specific IPAC practice audits were not conducted regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role. IPAC Lead acknowledged that the IPAC audits to ensure all employees were capable of carrying out the IPAC

skills necessary for their roles were not completed.

Failure to conduct IPAC practice audits increased the risk of staff not adhering to appropriate infection control protocols, potentially leading to the spread of infectious diseases among residents and staff members.

Sources: LTCH's IPAC audits, interview with IPAC lead and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

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