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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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: July 8, 2025
Inspection Number: 2025-1299-0005
Inspection Type: Complaint Critical Incident
Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation
Long Term Care Home and City: Ukrainian Canadian Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25 - 27, 2025 and July 2 - 4, and 8, 2025.

The following CI intake was inspected:

- Intake: #00148530 / CI #2809-000014-25 was related to allegations of improper care.

The following complaint intake(s) were inspected:

- Intake: #00148732 and Intake: #00150552 were related to a complaint about multiple aspects of care.

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

Resident Care and Support Services
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters To Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the suspicion of improper care of a resident that resulted in an injury, and the information upon which it was based to the Director.

The home received a complaint that included allegations of improper care of a resident, that resulted in an injury. Assistant Director Of Care (ADOC) and Senior Clinical Team Lead (SCTL) were aware of the concern on the same day, but did not report the incident to the Director until the subsequent day.

Sources: Review of Critical Incident report, internal investigation notes and interviews with SCTL and ADOC.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #002 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 responses provided to a written complaint made to the licensee, concerning the care of a resident, 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.

Sources: Review of response letter and interview with SCTL.