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

Public Report

Report Issue Date: July 8, 2025
Inspection Number: 2025-1299-0004
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 7 - 8, 2025

The following complaint intake was inspected:

- Intake: #00145973 was related to compliant about multiple aspects of care.

The following CI intake(s) were inspected:

- Intake: #00147201 / CI #2809-000013-25 was related to unknown cause of injury to a resident.
- Intake: #00149286 / CI #2809-000015-25 was related to a fall of a resident.

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

Resident Care and Support Services
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 (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 licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff for medication administration. The medication was to be administered, required specific directions for time of administration, however these instructions were not specified in the resident's clinical records. The Registered Practical Nurse (RPN) stated that they administered the medication to the resident on multiple occasions later than the required time in the absence of the indicated directions.

Sources: The resident's clinical records; interview with the RPN.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 a resident as specified in their plan. The resident's care plan directed for a device to be applied when the resident was using a particular assistive device, however an observation revealed the device was not in place, as specified in the

plan.

Sources: Inspector's Observations, a review of the resident's plan of care; and interview with the Personal Support Worker (PSW).

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