Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 26, 2013	2013_157210_0026	T-377	Complaint

Licensee/Titulaire de permis

ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION
60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4

Long-Term Care Home/Foyer de soins de longue durée

UKRAINIAN CANADIAN CARE CENTRE
60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 20, 21, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Director of Nursing Care (DONC), Physiotherapist (PT), Family member

During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed clinical records

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
Review of a clinical record reveals that in the first quarter of 2013 during evening care Resident #1 had a fall in her\his room from the wheelchair. After assisting with personal care a staff wheeled the resident from the washroom that is located in the resident room, to the middle area of the room. When staff tried to stop the wheelchair, Resident #1 slid from the wheelchair and fell with the face down on the floor. Resident #1 sustained facial injuries and was sent to hospital. Review of the clinical record and interview with staff confirmed that on the wheelchair cushion was a non-sliding mat that was applied several days before the fall. Interview with staff from different shifts confirmed that not all staff were informed about the application of a new implemented non-sliding mat in order to monitor resident and assess efficacy. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident SDM designated by the resident has been given an opportunity to participate fully in the development and implementation of the plan of care.
Interview with staff and review of the resident plan of care reveals that when a non-sliding mat was applied on Resident #1's wheelchair the resident SDM was not informed. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy "Occupational Health and Safety" for Safe purchasing, number ADM-OH&S-1.6, revised date May 2013, effective date May 2013, is complied with.
The policy provides a guideline for the Ukrainian Canadian Care Centre to assist in preventing the acquisition and use of products that may have an environmental or other health and safety risk inherent in the product. This policy applies to the purchase or acquisition of products, including furniture or equipment used in operations. In the case of furniture and equipment, the manager should determine or enquire about any known or apparent health and safety risks with the design or the materials used in the product that might pose a health and safety concern in ordinary use.
According to the interview with DOC and review of clinical record, when a new non-sliding mat was applied on Resident #1's wheelchair that was not evaluated from a health and safety perspective by managers. [s. 8. (1)]

Issued on this 27th day of November, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

SLAVICA VUCKO