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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 4, 2019	2019_634513_0008	027953-18, 028747-18	Critical Incident System

Licensee/Titulaire de permis

Slovenian Linden Foundation
52 Neilson Drive ETOBICOKE ON M9C 1V7

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

Dom Lipa
52 Neilson Drive ETOBICOKE ON M9C 1V7

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

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 13, 14, 15, 16 and 17, 2019.

During the course of the inspection, the following Critical Incident System (CIS) logs were inspected: log #027953-18, (CIS #2794-000025-18) related to medication administration and log #028747-18 (CIS #2794-000026-18) related to a fall.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and the Resident Care Coordinator.

The inspector performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, staff training records and the home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A Critical Incident System (CIS) report was initiated by the home and received by the

Ministry of Health and Long-Term Care, with amendments, on a specified date in 2018. The CIS indicated an error occurred related to a specified treatment.

A review of the census indicated on a specific date resident #002 and resident #003 were residing on a specific floor.

A review of resident #002's medical record indicated the resident was not receiving a specified treatment, however, on an identified date a specific procedure related to a specific treatment was requested by the physician prior to another procedure.

A review of resident #003's medical record indicated the resident had a medical condition that required a specific daily treatment with an identified medical management procedure specified by the physician. The resident had a moderate cognitive impairment and required extensive assistance with activities of daily living. A review of the progress notes on a specific date indicated the physician of resident #003 was notified of resident #002's medical management procedure result and prescribed a specific treatment based on this result.

A review of resident #003's physician orders and treatment records indicated resident #003 received a daily scheduled treatment, followed by a medical management procedure prescribed by the physician.

A review of resident #002's paper and electronic records indicated this resident was not prescribed, nor received, the above noted daily scheduled treatment. A review of the progress notes for resident #002 indicated a specific medical management procedure was prescribed prior to a medical procedure. The result of this procedure for resident #002 was reported to the physician of resident #003 in error. The physician, not aware that there was a second resident, prescribed a change to the treatment for resident #003 based on resident #002's result.

An interview with manager #101 confirmed that as a result of reporting resident #002's medical management procedure result to resident #003's physician, resident #003 received a specific treatment based on the result of resident #002's medical management procedure. The manager confirmed the resident was not injured. Staff were disciplined. In this instance the licensee did not ensure that the home was a safe and secure environment for resident #003 regarding evaluation of the specific medical management and subsequent change to the treatment for resident #003. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 5th day of June, 2019

[redacted]

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

Original report signed by the inspector.