Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
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Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022_1284_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Slovenian Linden Foundation

Long-Term Care Home and City
Dom Lipa, Etobicoke

Lead Inspector
Julie Ann Hing (#649)

Inspector Digital Signature
Julie ann Hing
Digitally signed by Julie ann Hing
Date: 2022.09.14 09:58:49 -04'00'

Additional Inspector(s)
Matthew Chiu (#565)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 3-5, and 8-12, 2022.

Inspectors Kehinde Sangill (#741670) and Reji Sivamangalam (#739633) were present during this inspection.

The following intake(s) were inspected:
Log #014981-22 was related to a proactive compliance inspection.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Food, Nutrition and Hydration
- Medication Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home

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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)

O. Reg. 246/22, s. 77 (4)

The licensee has failed to ensure that the planned menu items were offered and available at the lunch meal service on an identified home area.

Rationale and Summary:
The posted lunch menu on an identified home area indicated the second meal choice was egg salad with rye bread.

The inspector observed some residents were shown the choice of a croissant instead of rye bread on the show plate, and a resident received croissant instead of rye bread. This was brought to the Dietary Aide's (DA) attention, who advised that they were just provided with a supply of rye bread and was going to replace the croissant on the show plate, so that it matches the posted menu.

Sources: Observation of lunch meal service on August 3, 2022, on an identified home area, review of posted menu, interview with DA and other staff. [#649]

Date Remedy Implemented: August 3, 2022

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of a resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary:
Observation of a resident revealed discharge from an identified area of the body. This was brought to the Personal Support Worker (PSW) and Registered Nurse's (RN) attention. The

PSW acknowledged being aware of the discharge but failed to report it to the nurse, as they thought they already knew. The registered nurse was not aware of the concern.

Staff failure to collaborate with the nurse put the resident at risk of not receiving effective treatment.

Sources: Observation of a resident on August 5, 2022, interview with PSW, RN, and other staff. [#649]

WRITTEN NOTIFICATION PLAN OF CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
Observation indicated that a resident was administered fluids directly from a cup instead of via a spoon. Water served to the resident was not thickened to the correct consistency.

According to the resident's care plan they required thickened fluids to be administered via a spoon. The Registered Dietitian (RD) advised that the resident required thickened fluids via a spoon to limit the amount of fluid given related to a health risk.

The PSW acknowledged that the water served to the resident was not thickened to the correct consistency as clumps of thickener were observed at the bottom of the cup when stirred.

Failure to administer a resident's fluids via a spoon, and water served at the incorrect consistency put the resident at risk of choking.

Sources: Observation of a resident's lunch meal service on August 3, 2022, review of a resident's clinical records, interview with the PSW and other staff. [#649]

WRITTEN NOTIFICATION RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee has failed to ensure that they sought the advice of Residents' Council and Family Council in acting on the results of the survey.

Rationale and Summary:

The Executive Director (ED) acknowledged that the licensee had not sought the advice of Residents' Council and Family Council in acting on the results of the 2021 Resident and Family/Caregiver Experience Survey.

Sources: Interview with ED and review of the home's Resident/Family Experience Survey Overview for 2021. [#649]

WRITTEN NOTIFICATION DOORS IN A HOME

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

Non-compliance with: O. Reg. 246/22, s. 12. (1) 3.

The licensee has failed to ensure that a door leading to non-residential areas was equipped with a lock to restrict unsupervised access to the area by residents, and the doors leading to four non-residential areas were closed and locked when they were not being supervised by staff.

Rationale and Summary:
It was observed that there was no staff supervising the doors leading to the following areas:
- Bedpan washer room #159. The door was not closed, and the door latch was blocked with paper roll,
- Clean linen rooms #157 and #W104C. The doors were closed but not locked and door latches were blocked with paper and plastic rolls,
- Equipment room #146. The door was not closed and not equipped with a lock.

Staff stated that the home's clean linen rooms, bedpan washer rooms, and the equipment room mentioned above were non-residential areas. Each door leading to these rooms should be kept closed and locked to restrict unsupervised access to those areas by residents.

Sources: Observations on August 3 and 4, 2022; interviews with PSWs and the Director of Care (DOC). [#565]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 102 (2) (b).

The licensee has failed to ensure that staff offered or assisted residents with hand hygiene prior to eating, and staff avoided eating on resident home areas.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.4 (h) states that the licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary

(i) An observation revealed that residents were not offered or assisted with hand hygiene prior to the lunch meal service. Infection Prevention and Control (IPAC) Lead advised that blue cloths should have been used to clean residents' hands before and after meals, and the blue cloths did not have any antibacterial properties.

Failing to assist residents with hand hygiene and using cloths with no antibacterial properties increased the risk of transmission of infectious disease.

Sources: Observation on August 3, 2022, on an identified home area, interviews with IPAC Lead and other staff. [#649]

Rationale and Summary

(ii) Donuts were observed at a nursing station. The PSW acknowledged that they were eating donuts at the nursing station.

Public Health Ontario (PHO) Coronavirus (COVID-19): Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes indicated there should be no food or drink at the nursing station.

Failure of staff to follow PHO guidelines increased the risk of transmission of infection on the home area.

Sources: Observations on August 5, 2022, on an identified home area, PHO COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes – Published December 23, 2021, and interviews with the PSW and other staff. [#649]

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 (15).

The licensee has failed to ensure that the IPAC lead designated under this section works regularly in that position on site at the home for at least 17.5 hours per week.

Rationale and Summary:

The home had 64 licensed beds and had a staff designated as the lead for their IPAC, continuous quality improvement, falls prevention and management, and as their resident care coordinator.

The home's IPAC lead job description did not specify the number of work hours designated towards their IPAC lead responsibilities. Staff indicated that the home had not designated a minimum number of weekly hours for the IPAC lead position. The number of hours was unclear and would vary from week to week. There was no other record that indicated the IPAC lead worked in that position for at least 17.5 hours per week as required.

The non-compliance caused a risk of impact to the implementation of the home's IPAC program, practice, and standard.

Sources: IPAC lead job description; interviews with the IPAC lead and DOC. [#565]

WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEM

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with their medication management policy for destruction and disposal of all drugs in the home.

In accordance with O. Reg 246/22 s.11. (1) (b) the licensee was required to ensure that drugs to be destroyed were stored in a sealed one-way container until picked up by the medical waste company.

Rationale and Summary:
(i) Specifically, staff did not comply with the home's Drug Destruction and Disposal policy that indicated medications awaiting destruction were to be stored in a sealed one-way container until it was picked up by the medical waste company.

Observation of the medication disposal containers showed that the lids on the disposal containers were unlocked, and previously discarded medications accessible.

Failure to lock the lids on the disposal containers posed the risk of previously discarded medications being accessible.

Sources: Observation of disposal containers on August 4, 2022, review of Silver Fox Pharmacy Drug Destruction and Disposal policy (#9.1 reviewed date January 2022), interviews with DOC and other relevant staff. [#649]

Rationale and Summary:
(ii) Specifically, staff did not comply with the home's Medication Administration – Controlled Substance policy that indicated registered staff will update the individual controlled substance administration record after the medication dosage was dispensed.

Observation of a resident's medication administration indicated that the nurse had not signed the resident's narcotic record for the administration of a controlled drug at the time of administration. The nurse advised that the narcotic binder was too big, and there was no space on the medication cart to carry it.

Sources: Observation of medication administration to a resident on August 4, 2022, review of resident's e-MAR, review of home's Medication Administration – Controlled Substance policy (0004 reviewed date January 2022), interviews with DOC and other relevant staff. [#649]

WRITTEN NOTIFICATION QUARTERLY EVALUATION

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:
The home was unable to provide any evidence of this practice occurring in the home. According to Professional Advisory Committee (PAC) meeting minutes on December 8, 2021, it made no mention of the home's medication management system.

The home's failure to have an interdisciplinary team review at least quarterly of the effectiveness of the home's medication management system poses the risk of changes and improvements not being implemented.

Sources: Review of the home's PAC meeting minutes on December 8, 2021, and interview with DOC. [#649]

WRITTEN NOTIFICATION SAFE STORAGE OF DRUGS

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that a resident's drugs were stored in an area or a medication cart that was secure and locked.

Rationale and Summary:
After conducting an interview with a resident, a container of a prescribed cream on the resident's bedside table was observed. The resident told the inspector that staff applies the cream. The nurse acknowledged that the prescribed cream should not have been left on the resident's bedside table and removed it for safe keeping.

Leaving a resident's prescribed cream unattended at their bedside table poses the risk of other residents accessing it.

Sources: Observation of prescribed cream at a resident's bedside table on August 5, 2022, review of a resident's electronic-treatment administration record (e-TAR), interviews with RPN, and other staff. [#649]

WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s.140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
During observation of a resident's medication administration, they were administered an enteric coated tablet crushed. The instruction on the resident's medication pouch and electronic-medication administration record (e-MAR) indicated not to crush this tablet. The resident had a diet change approximately two weeks earlier and since then required their medications to be crushed. The DOC advised that the resident's enteric coated tablet was changed to a chewable.

Administering a crushed enteric coated tablet to a resident increased their risk of decreased drug absorption.

Sources: Observation of medication administration to a resident on August 4, 2022, review of a resident's e-MAR, interviews with the RPN and DOC. [#649]

WRITTEN NOTIFICATION MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 147 (3)

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary:
The home was unable to provide any evidence of this practice occurring in the home. According to Professional Advisory Committee (PAC) meeting minutes on December 8, 2021, made no mention of a review of medication incidents in the home.

The home's failure to complete a quarterly review of all medication incidents and adverse drug reactions that had occurred in the home poses the risk of changes and improvements not being implemented.

Sources: Review of the home's PAC meeting minutes on December 8, 2021, and interview with DOC. [#649]

WRITTEN NOTIFICATION ADDITIONAL TRAINING — DIRECT CARE STAFF

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 79/10, s. 221 (2).

The licensee has failed to ensure that all staff who provided direct care to residents received annual training provided for in the areas required under subsection 82 (7) of the Act related to pain management and skin and wound care.

Rationale and Summary:
Staff interviews and training records indicated the home used Surge Learning online courses to provide their annual training, for pain management and skin and wound care, to direct care staff in year 2021. Four direct care staff did not receive pain management training, and five direct care staff did not receive skin and wound care training as required. It was approximately nine to twelve per cent of direct care staff that did not receive their annual training under these two areas.

Sources: 2021 Surge Learning training records; interviews with Education Coordinator (EC) and the DOC. [#565]