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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 6, 2023
Original Report Issue Date: October 4, 2023
Inspection Number: 2023-1284-0002 (A1)
Inspection Type: District Initiated Critical Incident
Licensee: Slovenian Linden Foundation
Long Term Care Home and City: Dom Lipa,Etobicoke

Amended By	**Inspector who Amended Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.10.26 09:12:57 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

Change the Compliance Due Date (CDD) for Compliance Order #001 to November 30, 2023, as requested by the licensee.

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Long Term Care Home and City: Dom Lipa, Etobicoke	
Lead Inspector Joy Ieraci (665)	**Additional Inspector(s)** Noreen Frederick (704758)
Amended By Joy Ieraci (665)	**Inspector who Amended Digital Signature** Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.10.26 09:15:07 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

Change the Compliance Due Date (CDD) for Compliance Order #001 to November 30, 2023, as requested by the licensee.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20, 22, 25, 26, 27, 2023
The inspection occurred offsite on the following date(s): September 28, 2023, and October 3, 2023

The following intake(s) were inspected:

- Log #00097156 - District office-initiated inspection
- Log #00097150 - Critical Incident System (CIS) related to a fall with injury

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

Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints
Falls Prevention and Management

AMENDED 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 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary

The resident had a fall and sustained an injury. The plan of care had a fall intervention which had been in place for a few years for the resident.

A Personal Support Worker (PSW) and two Registered Nurses (RNs) indicated that at the time of the fall the resident did not require the intervention and was not being completed.

The RNs reviewed the resident's plan of care after the fall and acknowledged that they should have revised and removed the intervention from the plan of care.

There was a low risk to the resident when the plan of care was not revised when the intervention was no longer necessary.

Sources: Review of the resident's plan of care, and interviews with a PSW and two RNs. [665]

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)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, related to fall interventions.

Rationale and Summary

The resident was at risk for falls and their plan of care required staff to put in place an intervention for the resident.

A PSW told the inspector they had not implemented the intervention as per the plan of care.

The resident was at risk of injury if they had fallen when the intervention was not implemented.

Sources: Review of the resident's plan of care, and interview with a PSW. [665]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by two residents at all times.

Rationale and Summary

The residents did not have access to their call bells. The observations were verified by two PSWs.

The Director of Care (DOC) acknowledged that both residents needed to have their call bell accessible to them at all times.

Due to the home failing to provide access to the call bell, there was a risk that both residents will not receive the assistance they required including in case of an emergency.

Sources: Resident observations, review of the residents' care plan, and interview with the DOC. [704758]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that every verbal complaint made to the licensee concerning the care of a resident, a response was provided to the person who made a complaint 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.

Rationale and Summary

A resident made a verbal complaint and a response was provided by the Food Services Manager (FSM).

The FSM acknowledged they did not provide the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman when they provided their response to the resident.

Failure to provide the complainant with the Ministry's toll-free number and contact information for the patient ombudsman have reduced the choices the resident had to have their complaint addressed.

Sources: Review of Dom Lipa LTC Concern Log 2023, and interview with FSM. [665]

WRITTEN NOTIFICATION: CRITICAL INCIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 4.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

Rationale and Summary

The home submitted a CIS report, regarding a resident fall resulting in injury and transfer to hospital.

The DOC was aware of the change in the resident's health condition the following day of the fall, and acknowledged the CIS was submitted late.

There was no risk to the resident when the critical incident was not submitted to the Director on time, however, the home's management of critical incidents may not have been effective.

Sources: Review of CIS report and interview with DOC. [665]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Conduct an audit in two resident home areas (RHAs) to ensure that all alcohol-based hand rub (ABHR) has not expired, upon service of this order.

2) Maintain a record of the audit/s conducted, the RHA audited, the auditor, date(s) of the audits, results of the audit and any actions taken to address the audit findings.

3) Conduct weekly audits for four weeks to ensure that two identified PSWs perform hand hygiene when providing nourishment to residents, upon service of this order.

4) Conduct weekly audits for four weeks to ensure an identified PSW assists and supports residents with hand hygiene prior to providing nourishment, upon service of this report.

5) Re-train the PSWs in items #3 and #4, on the home's hand hygiene program.

6) Conduct weekly audits for four weeks to ensure that an identified RN and two PSWs wear the appropriate personal protective equipment (PPE) when providing direct care to residents who are on additional precautions.

7) Re-train the staff in item #6 on the appropriate selection and application of PPE when care is provided to residents on additional precautions.

8) For items #3, #4 and #6, maintain a record of the audits conducted, staff who was audited, the auditor, date(s) of the audits, results of the audit and any actions taken to address the audit findings.

9) For items #5 and #7, maintain a record of the training conducted, contents of the training, the trainer, staff that were trained and the date(s) of the training.

Grounds

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

1) The home has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, support for residents to perform hand hygiene prior to receiving snacks as required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary

A PSW provided a resident with their snack and did not support the resident in performing hand hygiene prior to receiving their snack.

The PSW acknowledged they did not support the resident with hand hygiene as required in the home's hand hygiene program.

The resident was at risk of infection transmission when they were not supported to perform hand hygiene prior to receipt of their snack.

Sources: Resident observation and interviews with a PSW and other staff. [665]

2) The home has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, that the hand hygiene program

included 70-90% ABHR as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

Expired Aloe Care ABHR pumps were observed in a resident's room and inside a resident activity room on one RHA.

The Executive Director (ED) indicated that the expired ABHR reduced the effectiveness of the ABHR and should not have been in the RHAs.

Residents and staff were at risk of infection transmission, since the use of expired ABHR reduced the effectiveness of the ABHR in the home's hand hygiene program.

Sources: Observations in two RHAs and interviews with the ED and other staff. [665]

3) The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

A) A PSW did not perform hand hygiene prior to handling food and after each resident contact when they provided snacks to two residents.

The PSW acknowledged they were supposed to perform hand hygiene but did not.

There was a risk of infection transmission to the two residents when the PSW did not perform hand hygiene.

Sources: Resident observation and interviews with a PSW and other staff. [665]

B) A PSW did not perform hand hygiene during a nourishment pass before the initial resident contact, before serving drinks, and after resident contact.

The DOC acknowledged that the PSW was expected to perform hand hygiene with each contact with residents.

Due to the PSW not performing hand hygiene before and after coming into contact with the resident

and their environment as well as when serving drinks, there was a risk of harm to residents related to infection transmission.

Sources: Nourishment observation, review of home's policy titled “Hand Hygiene”, Policy #RDL 1.13, last reviewed August 2022, and interviews with a PSW and DOC. [704758]

4) The home has failed to ensure that Additional Precautions were in accordance with the “IPAC Standard for Long-Term Care Homes April 2022”. Specifically, additional PPE requirements including appropriate selection application as required by Additional Requirement 9.1 (f) under the IPAC standard.

Rationale and Summary

A) A resident was on additional precautions and the additional precautions signage on their door indicated that eye protection was to be worn within two metres of the resident.

An RN provided care to the resident without wearing eye protection.

The RN confirmed that they should have worn eye protection when they provided care to the resident.

There was a risk of infection transmission to the RN, other residents and staff when eye protection was not worn by the RN.

Sources: Resident care observations; review of the resident's progress notes and additional precautions signage; and interviews with an RN and other staff. [665]

B) A resident was on additional precautions and the additional precautions signage on their door indicated that a long sleeved gown was to be worn for direct care.

Two PSWs were observed to have provided direct care to the resident without wearing a long sleeved gown and an RN verified the observation.

The PSWs acknowledged they should have worn the gown when they provided care to the resident.

There was a risk of infection transmission to the PSWs, other residents and staff when the gown was not worn when they provided care to the resident.

Sources: Resident care observations; review of the resident's progress notes and additional precautions signage; and interviews with PSWs, RN and other staff. [665]

This order must be complied with by November 30, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.