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

# Original Public Report

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| Report Issue Date: June 21, 2024 |
| Inspection Number: 2024-1284-0003 |
| Inspection Type:<br>Complaint<br>Critical Incident (CI) |
| Licensee: Slovenian Linden Foundation |
| Long Term Care Home and City: Dom Lipa, Etobicoke |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4 - 7 and 10 - 13, 2024

The following intake(s) were inspected:

- Intake #00114145 was a complaint related to multiple aspects of care.
- Intake #00114455 was a complaint related to multiple aspects of care.
- Intake #00116306 / CI #2794-000007-24 was related to respiratory outbreak.
- Intake #00117541 / CI #2794-000009-24 was related to fall of a resident.

The following intake was completed in this inspection:

- Intake #00118365 / CI #2794-000011-24 was related to respiratory outbreak.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

# 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)
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 the resident as specified in the plan for a resident.

Rationale and Summary
A resident's care plan stated a specific intervention was to be applied on the resident room's door when resident was in the room since the resident had a history of becoming upset when other residents entered their room.

During an observation, this intervention was not in place. A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) attempted to find this intervention, but it could not be located in the room and confirmed that the intervention was not applied as per the care plan.

The Director of Care (DOC) acknowledged that the expectation was that the specific intervention should have been applied if this intervention was part of the care plan.

Sources: Care Plan review of resident, Observations and Interview with the DOC, PSW and RPN.

Date Remedy Implemented: June 12, 2024

## WRITTEN NOTIFICATION: Duty of Licensee to Comply With Plan

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 a specific intervention that was set out in a resident's plan of care to mitigate the risk of injuries due to falls, was provided to the resident as specified in the plan.

Rationale and Summary
After a fall, a resident was sent to the hospital. The resident returned from hospital after several days. As per a review of the care plan, a specific intervention was

initiated to mitigate the risk of further injury upon return from the hospital.

Upon observation, it was noted the intervention was not applied. Registered Nurse (RN) confirmed that the intervention was not implemented. The DOC acknowledged that the specified intervention should have been implemented to prevent injuries related to falls.

Failure to ensure that the specific intervention was implemented for the resident as set out in their care plan could lead to an increased risk of injury in case of a fall.

Sources: Observation; review of resident's care plan, interview with RN and the DOC.

## WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
The licensee has failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury is implemented in the home for a resident.

In accordance with O. Reg 246 / 22 s. 11 (1) (b), the licensee was required to ensure that a specific assessment must be completed if resident had a fall and was on a specific type of medication; and must be complied with.

Specifically, the licensee has failed to complete a specific assessment after a resident fell.

Rationale and Summary
A Resident had a fall and at the time of the fall, the resident was on a specific type of medication.

As per home's Falls Prevention & Management Policy, the charge nurse was tasked with initiating a specific assessment if the resident was on this specific type of medication.

Review of physical and electronic chart could not identify the particular assessment completed after the fall. The DOC and RN acknowledged that the specific assessment was not completed.

Failure to complete a specific assessment in accordance with the home's policy, placed the resident at risk of not being properly assessed for post fall injuries.

Sources: Review of physical and electronic chart for the resident, Falls prevention and management policy, and interview of the DOC and RN.

## WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each

of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary
An outbreak of a communicable disease was declared by the public health unit, while the Director was first informed of this outbreak a day after.

IPAC Lead and DOC acknowledged that a critical incident report for outbreak of a disease of public health significance was not filed immediately after public health unit declared an outbreak.

Failure to communicate an outbreak of a disease of public health significance, did not have a direct impact on residents.

Sources: review of CI; DOC and IPAC Lead interview