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

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Public Report

Report Issue Date: January 6, 2025
Inspection Number: 2024-1284-0005
Inspection Type: Critical Incident
Licensee: Slovenian Linden Foundation
Long Term Care Home and City: Dom Lipa, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9, 10, 11, 13, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00128410 - Critical Incident System (CIS) 2794-000021-24 -related to Fall Prevention and Management
- Intake: #00128632 - CIS #2794-000022-24 - related to Resident care and Support Services

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
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: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non- residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary
During the inspection, the utility doors in two resident home area (RHA) were unlocked with key inside the door lock. The inspector opened the door and observed items inside. There were no residents in the vicinity at the time of the observations.

The Director of Care (DOC) #102 and the Executive Director (ED) #103 acknowledged that the identified doors were non-residential areas, and that the door should be locked with key not left unattended inside.

Sources: Observations during the inspection period, interviews with the DOC #102 and ED #103.

Date Remedy Implemented: December 9, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident was reassessed and plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A resident had a history of falls and sustained multiple falls on identified dates.

The home's Falls Prevention and Management policy indicated that interdisciplinary assessments and plan of care reviews are required when a resident's care needs change. A referral for falls was sent to the physiotherapist for an assessment of the resident for the falls. The resident's progress notes and clinical records revealed that the physiotherapy assessment was not completed.

Physiotherapist (PT) #109 reported that upon a resident fall, a PT assessment is conducted to ensure strategies and interventions are updated and acknowledged that the PT assessment was not completed for the resident.

Failure to ensure the resident was reassessed, and the plan of care reviewed when the resident's care needs changed increased the risk of not implementing an interdisciplinary care plan.

Sources: Review of resident progress notes and clinical record, , home's policy titled "Falls Prevention and Management" last approved March 2023, and interview with PT #109.

WRITTEN NOTIFICATION: MEDICATIONS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked

The licensee has failed to ensure that drugs were stored in a medication cart that was secured and locked.

Rationale and Summary
On an identified date, the inspector observed a medication cup with medication left unattended on top of a handrail in the hallway.

The DOC #102 and Registered Nurse (RN) #104 stated that medications should be stored inside the medication cart and not left unattended.

Failure to adhere to the medication storage protocols posed a risk to the safety of residents.

Sources: Observation on an identified unit, interview with RN #104 and the DOC.