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

Public Report

Report Issue Date: April 30, 2025
Inspection Number: 2025-1284-0002
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): April 25, 30, 2025
The inspection occurred offsite on the following date(s): April 29, 2025

The following intake was inspected:
- Intake: #00142834 related to a fall with injury.

The following intake was completed:
- Intake: #00143406 related to a fall with injury.

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

Falls Prevention and Management

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 (4) (b)

Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that a Personal Support Worker (PSW) and others involved in the different aspects of care of a resident collaborated with each other in the development of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A resident fell from an assistive equipment when they raised the safety mechanism of the equipment and sustained an injury. The PSW indicated that the resident had the behaviour of raising the safety mechanism prior to the fall. A Registered Practical Nurse (RPN) and a Registered Nurse (RN) indicated that the PSW and other PSW staff did not report the behaviour to them as required so that the resident's plan of care could have been reviewed and revised with appropriate interventions to ensure the resident's safety.

Sources: Critical Incident Report, a resident's progress notes and plan of care; and interviews with a PSW, RPN, RN and other staff.

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