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: August 7, 2025
Inspection Number: 2025-1284-0003
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 dates: July 31, 2025 and August 5-7, 2025

The following Critical Incident (CI) intakes were inspected:
Intake: #00149148 - [CI: #2794-000008-25] - related to falls prevention and management

Intake: #00153605 - [CI: #2794-000013-25] - related to an emergency including fire and unplanned evacuation

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

Housekeeping, Laundry and Maintenance Services
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident. The resident's care plan included conflicting instructions, indicating that staff should encourage the resident to use a specified device, while also stating the device was not required.

Sources: Resident's care plan; and interview with the Resident Care Coordinator (RCC).

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure a resident's provision of care was documented. The RCC stated the resident attended external follow up appointments, but there is no documentation about the dates of the appointments and outcomes.

Sources: Observation; resident's clinical records; and interviews with Registered Nurse (RN) and RCC.

WRITTEN NOTIFICATION: Plan of care

NC #003 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; or

The licensee has failed to ensure that a resident's plan of care was revised when they experienced a change in their condition, and required a specific intervention.

Additionally, when the intervention was no longer necessary, the resident's plan of care was not revised.

Sources: Observation; resident’s clinical records; and interviews with RN and RCC.