

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: September 17, 2025

Inspection Number: 2025-1284-0004

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): September 11-12, 15-17, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
-Intake: #00151205/ CI #2794-000012-25- related to fall with an 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 (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 a resident's plan of care was provided as specified in their plan.

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

i) A resident's plan of care directed staff to apply a specific falls prevention device. During an observation, the device was not applied to the resident.

Sources: Resident observation, review of the resident's clinical records, and interviews with the Personal Support Worker (PSW), and the Director of Care (DOC).

ii) A resident was required to receive physiotherapy on specific days. The resident did not receive physiotherapy sessions on a number of scheduled days during the week. The Physiotherapy Assistant (PTA) and the Registered Physiotherapist (RPT) both acknowledged that the sessions were not provided to as directed in their care plan.

Sources: Resident's clinical records, and interviews with the PTA, and the RPT.

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;
or

The licensee has failed to ensure that a resident's plan of care was revised when care needs changed. The resident sustained a fall that resulted in a negative health outcome. The plan of care for falls prevention and management indicated that a fall prevention device was to be applied to a specified mobility aid; however, the resident was using a different mobility aid.

Sources: Resident's clinical records, and interviews with the Registered Practical Nurse (RPN) and the DOC.