Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 20, 2021	2021_631210_0016	000643-20, 003762-20, 019544-20	Critical Incident System

Licensee/Titulaire de permis

Labdara Foundation
5 Resurrection Road Etobicoke ON M9A 5G1

Long-Term Care Home/Foyer de soins de longue durée

Labdara Lithuanian Nursing Home
5 Resurrection Road Etobicoke ON M9A 5G1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 22, 23, 24, 25, 29, 30, and 31, 2021.

During the course of the inspection the following Critical Incident System (CIS) intakes were inspected:
-Log #019544-20 and 000643-20, related to falls prevention program and
-Log #003762-20 related to transfer assistance.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Physiotherapy Assistant (PTA), and Environmental Services Manager (ESM).

During the course of the inspection the inspector observed provision of care, reviewed residents' clinical records, training records and home's policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for one resident set out the planned care for the resident.

The resident had a fall while performing an activity of daily living (ADL). A PSW was nearby, but could not prevent the fall. The resident tried to perform some ADLs and did not call the PSW who was in their room for help. After the fall, the Physiotherapist (PT) assessed the resident and documented that the resident should not be left unattended by staff during certain ADLs. It was the responsibility of registered staff to update the residents' care plan as per the PT's recommendations. The planned care for the resident not to be left unattended during certain ADLs was not transcribed in the resident's care plan for the PSWs to have access to.

Sources: observation of resident's room, review of resident's clinical record, interview with the resident, registered nurse and other staff. [s. 6. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting one resident.

On a specified date, PSW #108 found the resident being inappropriately transferred by PSW #110. The following day the resident presented with injuries.

The resident required two person assistance with transferring using a mechanical lift. PSW #110 had access to the resident's care plan and they were not able to explain why they did not follow the resident's care plan for transfer.

Staff did not use safe transferring and positioning techniques or devices when a resident was assisted with transferring, which resulted in injury to the resident.

Sources: observation of the resident's room, review of resident's clinical record, interview with the registered nurse and other staff. [s. 36.]

Issued on this 13th day of May, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.