Toronto Service Area Office
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Original Public Report

Report Issue Date November 1, 2022
Inspection Number 2022-1345-0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

Licensee
Labdara Foundation

Long-Term Care Home and City
Labdara Lithuanian Nursing Home, Etobicoke, ON

Lead Inspector
Rodolfo Ramon (704757)

Inspector Digital Signature

Additional Inspector(s)
Helina Leung (741076)

INSPECTION SUMMARY

The inspection occurred on the following date(s): October 4-7, 11-14, 2022

The following intake(s) were inspected:

- # 00004060 related to care services
- # 00004729 (CI: 2860-000004-22) related to prevention of abuse and neglect
- # 00004779 (CI: 2860-000009-22) related to prevention of abuse and neglect

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.4 states that the Licensee shall ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; as well as support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Rationale and Summary
During observations conducted, staff were observed wiping residents' hands with cleansing wipes that did not contain alcohol prior to their meal. According to the IPAC lead, hand hygiene was required to be done with an alcohol based product. This placed residents at risk of acquiring infectious diseases.

Sources: Observations, interview with IPAC lead.
[704757]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: with O.Reg. 246/22 s. 55 (2) (b) (ii)

The licensee has failed to ensure that resident #003 received immediate treatment and interventions to promote healing when skin alterations were identified.

Rationale and Summary

On an identified date, resident #003 was observed with skin alterations. PSW #100 identified the skin alterations at the beginning of their shift and reported it to RN #102. RN #102 acknowledged this was reported to them, however, no assessment was completed until the next incoming shift. RN #105 stated they assessed the skin alterations at the beginning of their shift and implemented interventions to promote healing.

RN #102 and the DOC verified that the skin alterations should have been assessed immediately. This delay in assessment prevented resident #003 from receiving immediate treatment and interventions to promote healing.

Sources: Progress notes, interviews with PSW #100, RN #103 and the DOC.
[704757]

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 S. 24(1)(2)

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk or harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an incident of alleged sexual abuse of resident #001 by resident #002.

The home's Abuse and Neglect Prevention Policy stated that a report of an alleged or witnessed incident of abuse or neglect must be reported to the MLTC immediately.

The RN was informed of the incident. The administrator acknowledged that the director was not informed of the incident until the next day.

Sources: CIS report #2860-000004-22, progress notes, Abuse and Neglect Prevention Policy 2.1 last reviewed March 2022, interview with RPN #110 and Administrator #106.

[071076]

WRITTEN NOTIFICATION POLICE NOTIFICATION

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg. 79/10, s. 98

The licensee has failed to ensure that the appropriate police service was immediately notified of a suspected incident of abuse to resident #001 that the licensee suspected may have constituted a criminal offence.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an incident of alleged sexual abuse of resident #001 by resident #002.

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

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During an interview with RPN #110, they stated that video footage was reviewed and revealed resident #002 had a sexual interaction with #001. The RN was informed of the incident.

The home's Abuse and Neglect Prevention Policy stated that the "Administrator/Designate shall notify the police immediately of any alleged, suspected or witnessed incident that the home suspects may constitute a criminal offense, including physical abuse, sexual abuse or financial abuse.".

The administrator acknowledged sexual abuse was considered a criminal offence and verified the police was not notified.

Sources: CIS report #2860-000004-22, progress notes, the home's Abuse and Neglect Prevention Program Policy 2.1 last reviewed March 2022, and interview with RPN #110 and Administrator #106.

[071076]

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk or harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an incident of alleged sexual abuse of resident #001 by resident #002.

The home's Abuse and Neglect Prevention Policy stated that a report of an alleged or witnessed incident of abuse or neglect must be reported to the MLTC immediately.

Administrator #106 reported that resident #001 was not able to consent, and sexual abuse of a resident was required to be reported to the Ministry as soon as possible, even when suspected. The administrator acknowledged that the director was not informed of the incident until the next day.

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Sources: CIS report #2860-000009-22, progress notes, the home's Abuse and Neglect Prevention Program Policy 2.1 last reviewed March 2022, and interview with RPN #110 and Administrator #106.

[741076]

WRITTEN NOTIFICATION POLICE NOTIFICATION

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of a suspected incident of abuse to resident #001 that the licensee suspected may have constituted a criminal offence.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an incident of alleged sexual abuse of resident #001 by resident #002.

The home's Abuse and Neglect Prevention Policy stated that the "Administrator/Designate shall notify the police immediately of any alleged, suspected or witnessed incident that the home suspects may constitute a criminal offense, including physical abuse, sexual abuse or financial abuse.".

According to the progress notes, RPN #110 found resident #002 having a sexual interaction with resident #001. The administrator acknowledged sexual abuse was considered a criminal offence and verified the police was not notified.

Sources: CIS report #2860-000009-22, progress notes, the home's Abuse and Neglect Prevention Program Policy 2.1 last reviewed March 2022, interviews with RPN #110 and Administrator #106.

[071076]