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
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Original Licensee Report

Report Issue Date: December 04, 2023	
Inspection Number: 2023-1345-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Labdara Foundation	
Long Term Care Home and City: Labdara Lithuanian Nursing Home, Etobicoke	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 16-17 and 20-24, 2023.

The following intake(s) were inspected:

- Intake Log #00091297/Critical Incident (CI) #2860-000011-23 – related to an unwitnessed fall
- Intake Log #00099294 – complaint related to resident care
- Intake Log #00099790/ CI #2860-000019-23 - related to COVID-19 outbreak

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

Continence Care
Falls Prevention and Management
Infection Prevention and Control
Medication 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

Duty of licensee to comply with plan

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.

Rationale and Summary

1) A resident's clinical records indicated that staff were expected to check whether the resident required care at specified times of the day.

Multiple observations were completed during inspection, and it was observed that a resident was not checked if they required care at specific times of the day as confirmed by the staff.

The home stated that staff were expected to bring a resident into their room to check if they required care at the times indicated. All staff interviewed stated that if a resident was not checked if they required care as indicated in their clinical record, the care was not provided as specified.

2) A resident's clinical records indicated that if they exhibited responsive behaviours during care, staff were expected to provide care in bed.

During observation, a resident was observed displaying responsive behaviors and staff did not provide care to the resident in bed as specified in the plan. All interviewed staff stated that if a resident had responsive behaviours staff were expected to provide care in bed for safety.

3) A resident's clinical records indicated that they required two-person assistance for care.

During observation, a staff confirmed that they assisted a resident alone preparing the resident for the transfer and called another staff only for the actual transfer process. All interviewed staff stated that the resident required two-person assistance for all transfers including the preparation for transfer.

There was a risk of injury to a resident when their plan of care was not followed as specified.

Sources: Resident observations, a resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director any written complaint that was received concerning the care of a resident.

Rationale and Summary

The home received a written complaint regarding the care of a resident.

The home confirmed that the written complaint was not forwarded to the Director. The homes policy indicated a written complaint shall be immediately forwarded to Ministry of Long-Term Care (MLTC) Director using the CI online reporting.

There was no risk to a when a complaint regarding their care was not immediately forwarded to the Director.

Sources: Review of the home's written complaint, interviews with complainant and staff.

[723]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had a fall, a post fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A resident sustained a fall with injury and subsequently transferred to the hospital for treatment. A resident's clinical records indicated that the post fall assessment was not completed following the fall. The home's policy indicated that staff should document post fall assessments using a specified tool.

The staff who attended to a resident after the fall incident confirmed that that the post fall assessment was not completed. The home stated that staff were expected to complete a post fall assessment for all fall incidences.

Failure of the home to complete a post fall assessment for a resident increased their risk of injury and further incidents.

Sources: A resident's assessment records, Home's Policy: Fall-Resident, 05-02-01 Last Revised, 05/2023 and staff interviews.

[723]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the residents' right to have their Personal Health Information (PHI) within the meaning of the PHI Protection Act, 2004 was kept confidential in accordance with the Act and was fully respected and promoted.

Rationale and Summary

A medication pass was observed in a home area. A staff was observed carrying out a medication pass with their medication cart left in the main lobby next to the elevator with the Electronic Medication Administration (EMAR) screen open.

The staff confirmed that the EMAR screen should have been kept hidden when unattended for privacy. The home stated that staff were expected to protect residents' privacy and personal health information at all times.

Failure of the home to keep screens with residents' PHI protected breached their right for confidentiality.

Sources: Observations in the home and staff interviews.

[723]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that medications were kept secured and locked.

Rationale and Summary

A medication pass was observed in a specific home area. The staff was observed administering medications to three different residents with the medication cart left unlocked and unattended.

The staff confirmed that the medication cart should be kept locked when unattended. The home stated that staff were expected to keep medication carts locked when unattended.

There was a risk of unauthorized medication access when medication carts were left unlocked when unattended.

Sources: Observations in the home and staff interviews.

[723]