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 Public Report

Report Issue Date: September 26, 2024
Inspection Number: 2024-1345-0002
Inspection Type:
Other
Complaint
Critical Incident

Licensee: Labdara Foundation
Long Term Care Home and City: Labdara Lithuanian Nursing Home, Etobicoke

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

September 3-6, 9-12, 16 and 17, 2024, on-site
September 13, 2024, off-site

The following Critical Incident (CI) intake(s) were inspected:

- Intakes: #00114375/ CI#2860-000010-24, #00121993/ CI #2860-000022-24, #00124580/ CI #2860-000024-24 were related to fall prevention and management.
- Intakes: #00120783/ CI #2860-000017-24, #00121110/ CI #2860-000018-24 were related to staff-to-resident abuse.
- Intake: #00121784/ CI #2860-000021-24 was related to improper wound care.
- Intake: #00121605 was related to an outstanding Emergency Planning Annual Attestation.

- Intake: #00115185/ CI #2860-000012-24 was related to a disease outbreak.

The following complaint intakes were inspected:

- Intake: #00116305 was a complaint related to resident discharge.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance Services

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that a resident's device was kept in good repair.

Rationale and Summary:
On an identified date, a resident got out their bed, sustained a fall, and was sent to the hospital. According to the plan of care, the resident was at risk for falls, and a fall prevention strategy was to be in place and in working condition while in bed. A Personal Support Worker (PSW) indicated that at the time of the fall, the device was not functioning. A record review showed that a service requisition form for the repair of the device was submitted to the maintenance department after the fall, noting that the device was not in good working order. The Critical Incident System (CIS) report submitted to the director also indicated that the device was not operational at the time of the fall. Additionally, the Director of Care (DOC) confirmed that the device was not working but should have worked to alert the staff when the resident attempted to leave the bed.

Failure to ensure that the device was in good repair, placed the resident at risk for injury as a result of a fall.

Sources:
Resident's plan of care, Physical Plant Service Requisition form and CIS report, interview with PSW and DOC.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable

directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The Licensee has failed to ensure that Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health Effective: April 2024 was followed in the home. In accordance with these recommendations the Licensee was required to ensure that Alcohol-based hand rubs (ABHR) must not be expired.

Rationale and Summary
During observations on two different dates, several expired alcohol-based hand rub (ABHR) products were discovered in various home areas and resident rooms, with expiration dates ranging from May 2016 to April 2024. Two housekeepers confirmed that these products were expired and they were not be used.

The Infection Prevention and Control (IPAC) Lead/ Staff Educator indicated that the responsibility for replacing expired hand sanitizers was a team work within the home and admitted that it was an oversight to use expired products. They also acknowledged that the expired products could degrade and lose their effectiveness.

The use of expired products in the home increased the risk of infectious disease transmission to the residents.

Sources: Observations, review of Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024, Interview with two Housekeepers, IPAC lead/ Staff Educator.