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

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Public Report

Report Issue Date: January 15, 2025
Inspection Number: 2025-1345-0001
Inspection Type: Critical Incident
Licensee: Labdara Foundation
Long Term Care Home and City: Labdara Lithuanian Nursing Home, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7, 9, 13, 14, 15, 2025.
The inspection occurred offsite on the following date(s): January 8, 2025.

The following intake(s) were inspected:

• Intake: #00135184 / Critical Incident System (CIS) #2860-000036-24, was related to an outbreak.
• Intake: #00134076 / CIS #2860-000034-24, was related to a resident fall resulting in an injury.

The following intakes were completed in this inspection:
• Intake: #00128448 / CIS #2860-000028-24, intake #00128918/ CIS #2860-000029-24, intake: #00130540 / CIS #2860-000030-24, intake #00135076/ CIS #2860-000035-24, and intake #00135436/ CIS #2860-000037-24, were related to an outbreak.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 all cleaning products being used to clean contact surfaces were not expired as recommended by the Chief Medical Officer of Health (CMOH).

An expired container of disinfectant wipes used to clean contact surfaces was observed on a resident home area (RHA). The wipes expired February 2024. In addition, a bottle of disinfectant solution also used for cleaning contact surfaces, was observed in housekeeper's storage closet, which expired March 2023.

On January 13, 2025, the expired cleaning products were removed from the RHA and housekeeper's storage room.

Sources: Observation on January 7, 2025, review of Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024, and interviews with staff.

Date Remedy Implemented: January 13, 2025

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that after a confirmed respiratory outbreak, symptoms were appropriately recorded for seven symptomatic residents on the outbreak line list.

Sources: Residents' clinical records and interviews with staff.