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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: November 7, 2024

Inspection Number: 2024-1284-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Slovenian Linden Foundation

Long Term Care Home and City: Dom Lipa, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19 - 20, 23 - 26, 2024 and October 1, 3, 9 and 10, 2024.
The inspection occurred offsite on the following date(s): October 15, 2024.

The following Critical Incident System (CIS) intakes were inspected:
- Intake: #00121056, CIS #2794-000016-24 was related to fall prevention and management.
- Intake: #00126507, CIS #2794-000020-24 was related alleged neglect of a resident.

The following Complaint intake was inspected:
- Intake: #00121185 was related to admission to the home.

The following CIS intake was completed:
- Intake: #00119569, CIS #2794-000014-24 was related to fall prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee failed to ensure that Personal Support Workers (PSW) and registered staff collaborated in the assessment of a resident when they experienced a change in health status.

Rationale and Summary:

The resident had a change in their health status while assisted by the PSWs during care. A PSW stated that they did not report the incident to the registered staff.

The registered staff member confirmed that they did not receive any reports from the PSWs during their shift about the resident's change in status, and no assessment

was completed.

The Director of Care (DOC) acknowledged that the PSWs should have immediately reported the resident's status change to the registered staff but failed to do so.

Failure to communicate and collaborate regarding the resident's change in status put the resident at risk of not receiving a timely assessment.

Sources: CIS report, resident's clinical records, interviews with staff members.

WRITTEN NOTIFICATION: Licensee consideration and approval

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

The licensee failed to ensure that withholding an applicant's admission approval was in accordance with circumstances permitted in the legislation.

Rationale and Summary:

The home withheld the applicant's approval for admission, citing a lack of nursing expertise to manage the care needs associated with responsive behaviours.

The Executive Director verified the home had a responsive behaviour program with trained staff members.

Withholding the applicant's approval for admission without appropriate grounds delayed the applicant's placement in their preferred home.

Sources: The written notice to the applicant, interviews with Executive Director and Placement Co-ordinator with Ontario Health at Home.

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (c)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(c) an explanation of how the supporting facts justify the decision to withhold approval.

The licensee failed to ensure that the written notice to an applicant regarding the withholding of admission approval set out an explanation of how the supporting facts justified the decision to withhold approval.

Rationale and Summary:

The applicant's admission approval to the home was withheld, and a written notice was provided. However, the notice did not include an explanation of the supporting facts justifying the home's decision to withhold the approval.

The Executive Director acknowledged that the written notice lacked the required information.

Withholding admission approval without the required information could have delayed the applicant's timely placement to the home of their choice.

Sources: The written notice to the applicant, interview with the Executive Director.

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(d) contact information for the Director.

The licensee failed to ensure that the written notice to an applicant for withholding approval for admission included the contact information for the Director.

Rationale and Summary:

The applicant's admission approval to the home was withheld, and a written notice was provided. The notice did not include the contact information for the Director.

The Executive Director acknowledged that the written notice lacked the required information.

The lack of the Director's contact information in the notice might hinder the applicant's ability to act on the home's decision.

Sources: The written notice to the applicant, interview with the Executive Director.

WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure that a resident's substitute decision-maker (SDM) was notified of the results of the investigation into an allegation of neglect after its completion.

Rationale and Summary:

The home received a complaint from a resident's SDM, alleging neglect by a staff member toward the resident. The home's response letter to the resident's SDM did not include the investigation results that had been conducted after receiving the complaint.

The DOC acknowledged that the response letter to the resident's SDM did not contain the required information.

Failure to provide the SDM with the investigation results could affect their ability to effectively participate in the resident's care, potentially leading to unresolved issues

and thereby compromising the resident's safety and well-being.

Sources: Resident's health records and the interview with the DOC.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 1.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The licensee failed to ensure that the CIS report related to the alleged neglect of a resident included the description of the incident, the area or location of the incident, and the date and time of the incident and the events leading up to the incident.

Rationale and Summary:

A report was submitted to the Director regarding the investigation into alleged neglect of a resident. The report did not include include the description of the incident, the area or location of the incident, the date and time of the incident, or the events leading up to the incident.

The DOC acknowledged that the CIS report did not include the required information.

Incomplete information about critical incidents could hinder the inspection process and delay the Director's response.

Sources: CIS report, Resident's health records and the interview with the DOC.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident.

The licensee failed to ensure that the CIS report related to the alleged neglect of a resident included names of any staff members or other persons who were present at the incident.

Rationale and Summary:

A report was submitted to the Director regarding the investigation into alleged neglect of a resident. The report did not include the names of any staff members or other persons who were present at the incident.

The DOC acknowledged that the CIS report did not include the required information.

Incomplete information about critical incidents could hinder the inspection process and delay the Director's response.

Sources: CIS report, Resident's health records and the interview with the DOC.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to ensure that the CIS report related to the alleged neglect of a resident included actions taken in response to the incident.

Rationale and Summary:

A report was submitted to the Director regarding the investigation into alleged neglect of a resident. The report did not include the actions taken in response to the incident, specifically:

i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The DOC acknowledged that the CIS report did not include any of the above required information.

Incomplete information about critical incidents could hinder the inspection process and delay the Director's response.

Sources: CIS report, Resident's health records and the interview with the DOC.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the

licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure that the CIS report related to the alleged neglect of a resident included the analysis and follow-up actions taken.

Rationale and Summary:

A report was submitted to the Director regarding the investigation into alleged neglect of a resident. The report did not include the analysis and follow-up actions, specifically:

i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

The DOC acknowledged that the CIS report did not include the required information.

Incomplete information about critical incidents could hinder the inspection process and delay the Director's response.

Sources: CIS report, Resident's health records and the interview with the DOC.

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002