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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Public Report

Report Issue Date: April 25, 2025

Inspection Number: 2025-1345-0003

Inspection Type:
Complaint
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): April 9, 10, 14 - 17, 22, 24 and 25, 2025.

The following Critical Incident System (CIS) intake was inspected:
• Intake: #00141174, CIS #2860-000002-25 related to a disease outbreak.

The following Critical Incident System (CIS)intake was completed:
• Intake: #00137984, CIS #2860-000001-25 related to a disease outbreak.

The following Complaint intake was inspected:
• Intake: #00143336 related to multiple care concerns of a resident.

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

Resident Care and Support Services
Infection Prevention and Control

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 (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 has failed to ensure that the registered staff collaborated with the physician in assessing a resident when they had a change in their health status.

A registered staff member was informed about a concerning health issue with the resident. However, the resident's attending physician was not informed immediately. Furthermore, the physician was not informed when staff were unable to collect the sample for a diagnostic test they ordered to assess the health issue. The resident's symptoms worsened, and they were subsequently hospitalized.

Sources: Resident's clinical records and interview with the staff member.

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 symptoms were recorded on every shift for the symptomatic residents after they were placed on additional precautions related to the confirmed outbreak.

A confirmed outbreak was declared in the home and prior to the outbreak, symptomatic residents were identified. Symptom recording was not completed on multiple shifts for a number of symptomatic residents who were placed on additional precautions.

Sources: Residents' health records and interview with a staff member.