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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 18, 2023	
Original Report Issue Date: August 18, 2023	
Inspection Number: 2023-1496-0003 (A1)	
Inspection Type: Critical Incident	
Licensee: Kristus Darzs Latvian Home	
Long Term Care Home and City: Kristus Darzs Latvian Home, Woodbridge	
Amended By Chinonye Nwankpa (000715)	**Inspector who Amended Digital Signature** Chinonye Nwankpa (000715)

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct the Licensee Report Issue date from August 16, 2023 to August 18, 2023.

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Lead Inspector Chinonye Nwankpa (000715)	**Additional Inspector(s)** Nicole Ranger (189)
Amended By Chinonye Nwankpa (000715)	**Inspector who Amended Digital Signature** Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2023.10.18 09:50:51 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct the Licensee Report Issue date from August 16, 2023 to August 18, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2023 and August 1, 2, 3, 2023.
The inspection occurred offsite on the following date(s): August 4, 2023.

The following intake(s) were inspected in this Critical Incident Inspection:

- Intake: #00091313 - IL-14844-AH/2997-000002-23 – related to a resident's fall.
- Intake: #00092406 - IL-15390-AH/2997-000003-23 – related to a resident's fall.

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

Infection Prevention and Control
Falls Prevention and Management

AMENDED 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 (10) (b)

The licensee failed to ensure that a resident's plan of care was revised when the care set out in the plan was no longer necessary.

Rationale and Summary
A resident's care plan stated specific assistive devices were to be applied by staff. Furthermore, the resident's care plan indicated the height of their bed was to be adjusted for safe transfer in and out of bed, however two different heights were specified. Lastly, the care plan noted that the resident could not weight bear on one of their legs.

A Personal Support Worker (PSW) confirmed that the resident no longer used the specified assistive devices and that the bed was supposed to be adjusted to one specific height because the resident was self-transferring. The Physiotherapist (PT) shared that resident was capable of weight bearing on both legs, and that the care plan ought to have been updated.

The RAI Coordinator and Director of Care (DOC) acknowledged that the care plan had not been updated to reflect the changes to resident's care needs, specifically that the above mentioned interventions should have been discontinued.

Failing to revise the care plan when the resident's needs changed could have increased the risk of harm to the resident.

Sources: Resident's care plan and Kardex; interviews with PSW, PT, RAI, and DOC

[000715]

WRITTEN NOTIFICATION: General Requirements

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the falls prevention and management program, including assessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to a fall of a resident which resulted in an injury for which they were taken to the hospital.

When the resident's fall was first discovered, Registered Nurse (RN) stated they performed an assessment before the resident was transferred off the floor. Review of the resident's clinical records identified there was no documentation of the results of this assessment. The DOC acknowledged that RN had not documented the assessment using the specified assessment tool.

The RN reassessed the resident after the fall occurred, and they found there was a change in the resident's condition. The resident's clinical records did not include details of the reassessment, the interventions, or the resident's response to the interventions.

The DOC acknowledged that the documentation did not include all aspects of care provided to the resident as per the Home's policy and expectations.

There was risk of harm indicated when the staff failed to document their assessments, interventions and the resident's response to interventions, as it could impact the home's ability to monitor changes in their condition.

Sources: Resident's clinical records and progress notes; interview with RN and DOC.

[000715]

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)

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

Rationale and Summary
The home's Falls Prevention and Management policy directed registered staff to complete a Head Injury Routine (HIR) assessment for all unwitnessed falls or when head injury was suspected. The policy noted

the HIR was to be completed every hour for the first four hours, then every four hours for the next 24 hours.

Record review showed the resident had an unwitnessed fall and only one HIR assessment was completed by Registered Practical Nurse (RPN) after the fall. The RPN and RN both confirmed they did not complete the subsequent hourly assessments before the resident's hospital transfer.

The DOC acknowledged that the HIR was not completed hourly as per the Home's policy.

Lack of proper monitoring of the resident through the HIR assessment increased the risk of delayed response to the change in the resident's condition.

Sources: CI report, video surveillance recording, Fall Prevention and Management policy, no date, resident's clinical records and progress notes, HIR; interviews with RPN, RN, and DOC.

[000715]

WRITTEN NOTIFICATION: Additional Training- Direct Care Staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training provided for in the areas required under subsection 82 (7) of the Act related to falls prevention and management.

Rationale and Summary
After a resident sustained a fall, a PSW and RPN performed an improper transfer technique to assist the resident off the floor. Review of the annual falls prevention and management training records for 2022 revealed the PSW and RPN did not complete their training. The PSW and RPN both confirmed they did not do their falls prevention and management courses. The DOC acknowledged their annual courses were incomplete.

Sources: Staff training records of RPN and PSW; interviews with RPN, PSW and DOC.

[000715]

COMPLIANCE ORDER CO #001 Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Conduct audits of fall prevention interventions, at minimum of one resident on each day and evening shift for a period of three weeks following service of this order.
2. Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to falls.

Rationale and Summary
The home submitted a CI report to the Director related to a fall of a resident that resulted in a significant change in their status.

A resident was at risk for falls and had a history of unsteady gait. The care plan directed staff to ensure that specific fall prevention interventions were in place.

Review of video surveillance identified that the specific fall interventions were not in place prior to their fall. The resident was observed to self transfer and they sustained a fall. The resident was assessed by RPN and RN, who discovered an injury and transferred the resident to hospital.

The DOC, RN, and RPN confirmed that the specific fall interventions were not in place at the time of the fall. The DOC acknowledged that staff did not follow the resident's plan of care for fall prevention.

Failure to follow the care planned fall interventions placed the resident at an increased risk of harm because of the fall.

Sources: Resident's written plan of care, progress notes, homes investigation notes, video footage, CIS report, interviews with PSW, RPN, RN, and DOC

[189]

This order must be complied with by September 15, 2023

COMPLIANCE ORDER CO #002 Transferring and Positioning Techniques

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate all PSWS and registered staff on the home's Zero Lift policy, on transferring a resident post fall, and procedures for staff when a resident has fallen by the compliance due date of this order.
2. Maintain a record of the education, including the content, date, signatures of staff who attended and the staff member who provided the education.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques while assisting residents.

Rationale and Summary
i) A resident sustained a fall and was assessed by the RPN who suspected a fracture. A PSW manually lifted the resident off the floor. The resident was further assessed by the RPN and RN then was transferred to hospital.

The home's Zero lift policy stated there should be no manual lifts for non-weight bearing residents. The PSW reported they were not instructed by the registered staff not to manually lift the resident. The RPN stated they suspected a fracture, and the resident was non weight bearing prior to the PSW arriving. The RPN and PSW stated that a device was to be used if a resident was suspected to have an injury and confirmed that a device was not used.

The DOC stated since the resident experienced pain and staff suspected fracture post-fall, the resident should not have been moved or manually transferred off the floor. The DOC acknowledged the staff did not follow the home's Zero Lift policy.

Failure to ensure that the PSW used a safe transferring technique placed the resident at risk of further injury.

Sources: Resident's written plan of care, progress notes, homes investigation notes, video footage, CIS report, Safe Handling and Assessing Resident's policy, no date; interviews with PSW, RPN, RN, and DOC.

[189]

ii) A resident had an unwitnessed fall. Before the fall incident, the resident was seen on video surveillance self-propelling on their unit, using a specific positioning device. A PSW confirmed that the resident was able to mobilize themselves independently and would self-transfer. The PSW further stated that the resident had the specific positioning device applied all the time.

The Physiotherapist (PT) indicated that this positioning device was contraindicated in residents who self-transfer and self-propel. Furthermore, the falls risk assessment revealed that the resident was at risk for falls.

The resident was at increased risk of falling and injury when the Home used an unsafe positioning device.

Sources: Video surveillance recording, falls risk assessment; interviews with PSW and PT.

[000715]

iii) Review of video surveillance footage identified a resident was transferred without a device after they sustained a fall. The RN, RPN and PSW who were present acknowledged the resident was transferred manually by multiple staff members by physically lifting the resident off the floor. RPN and PSW noted that the resident did not participate in the transfer as they did not weight bear at the time of the fall incident. The home's Safe Handling and Assessing Resident's policy included a Zero Lift policy which stated there should be no manual lifting for non-weight bearing residents.

The DOC acknowledged that staff did not follow the home’s policy of using a device after a fall.

There was risk of injury when staff used an unsafe technique to transfer the resident after the fall incident.

Sources: CI report, video surveillance recording, falls risk assessment, Safe Handling and Assessing Resident's policy, no date; interviews with PSW, PSW, PT, RPN, RN, and DOC.

[000715]

This order must be complied with by September 15, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.