

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

Public Report

Report Issue Date: July 9, 2025

Inspection Number: 2025-1496-0003

Inspection Type: Critical Incident

Licensee: Kristus Darzs Latvian Home

Long Term Care Home and City: Kristus Darzs Latvian Home, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 7-9, 2025

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

Intake: #00148243 - related to resident care and services

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) (b)



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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,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of the resident's care collaborated with each other in the development and implementation of the plan of care.

When a resident exhibited responsive behaviours, registered staff implemented a prescribed treatment. Following the treatment, the registered staff and a Personal Support Worker (PSW) did not communicate with each other to determine whether the treatment was effective in order to coordinate the provision of care during the shift. As a result, the resident did not receive the specified care in a timely manner.

Sources: Resident's clinical record, home's investigation record, interviews with the Behavioural Support Ontario (BSO) Lead, and PSWs.



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