

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:** November 14, 2025

**Inspection Number:** 2025-1496-0005

**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): November 7, 12 to 14, 2025

The following intake(s) were inspected:

- Intake: #00161487 - Critical Incident System (CIS) 2997-000007-25 - related to Falls Prevention and Management

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

Medication Management  
Falls Prevention and Management

## 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.

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Registered staff members did not collaborate with the physician on the resident's post-fall medication management.

A resident sustained a fall with injury. The registered staff did not consult with the physician (MD) to determine and assess a specific medication prior to administration.

The Director of Care (DOC) and the Assistant Director of Care (ADOC) indicated that the registered staff are to notify the MD when a resident sustains a fall with injury to obtain further medical directions.

**Sources:** Review of home's investigation, resident's clinical records and interviews with the Registered Practical Nurse (RPN) Registered Nurse (RN), DOC, ADOC and other staff.

## WRITTEN NOTIFICATION: Falls Prevention and Management

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

### Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The home's Falls Prevention and Management policy directed registered staff to complete a thorough assessment of the resident, and a Head Injury Routine (HIR) assessment for all unwitnessed falls or when head injury was suspected. The policy also noted that the physician is to be notified of a fall.

A resident experienced an unwitnessed fall and experienced a negative health outcome. The home's investigation notes revealed that a RPN did not complete an immediate post fall and head to toe assessment, the HIR was not completed in its entirety, and that a RN did not complete a post fall assessment nor did they contact the MD promptly to report the incident of a fall with injury.

The DOC acknowledged that the registered staff did not complete the required assessments and notification as required.

**Sources:** Review of home's investigation, disciplinary letters of RPN and RN, resident's clinical

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records and interviews with the RPN, RN, DOC and other staff.

## WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)**

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

A RPN did not comply with the home's "PRN Medication Utilization" policy, when they administered a medication to a resident in an unsafe position. The resident sustained a fall and negative health outcome as a result.

**Sources:** Review of home's investigation, resident's clinical records, home policy titled "PRN Medication Utilization", and interviews with the RPN, DOC and ADOC.



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**Inspection Report Under the  
Fixing Long-Term Care Act, 2021**

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