Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2019	2019_641665_0015	006638-19, 006763-19, 009205-19	Critical Incident System

Licensee/Titulaire de permis

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

Long-Term Care Home/Foyer de soins de longue durée

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 5, 9, 10 and 12, 2019.

The critical incident system (CIS) report #C533-000008-19 related to transferring and positioning was inspected.

The following follow up logs were inspected:
- Log # 006638-19 related to abuse
- Log #006763-19 related to plan of care

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (A-DOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Quality Lead (QL), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, clinical records were reviewed, resident care observations conducted, reviewed training records and home's policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_641665_0005	665
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_641665_0004	665

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that PSWs #109 and #111 used safe transferring and positioning techniques when assisting resident #001.

The home submitted a critical incident system (CIS) report for an incident that occurred on an identified date and time. The CIS report and a review of the progress notes indicated that on the identified date, resident #001 was being transferred by PSWs #109 and #111 with an identified mechanical device in a specified resident home area. During the resident's transfer, the resident sustained injury to an identified area of the body requiring treatment in hospital.

In interviews, PSWs #109 and #111 indicated that resident #001 was being transferred from their mobility device to a specified chair with the identified mechanical device. PSW #111 initiated lifting the resident with the mechanical device when the resident made a noise and observed injury to the resident. The PSWs stated that the mechanical device was positioned too close to the wall, which caused the resident's injury.

In an interview, the A-DOC indicated that PSW #111 was disciplined and both PSWs received safe use of equipment training by the home's physiotherapist. The A-DOC confirmed that PSWs #109 and #111 did not use safe transferring techniques during the transfer of resident #001.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On March 18, 2019, compliance order (CO #001) from inspection #2019_641665_0004 was made under LTCHA, 2007, s.6(7) was issued:

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee was ordered to:

a) Ensure that any resident that is provided with an identified safety device is attached to the resident and their mobility aide as per the plan of care and is working. In addition, any resident that is provided with another identified type of the safety device as per the plan of care is applied to the resident's mobility aide and is working.

b) Develop an on-going auditing process to ensure that the identified safety device used for any resident are applied and working, and include who will be responsible for doing the audits and evaluating the results. The home is required to maintain a documentation record of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

The compliance due date (CDD) was June 19, 2019.

The licensee completed step (b) in CO #001.

The licensee failed to complete step (a) in CO #001.

A record review of resident #002's plan of care indicated the resident used an identified safety device on their mobility aide and directed staff to ensure the safety device was on and working.

During observations conducted on an identified date and time, PSWs #104 and #105 transferred resident #002 from their mobility aide to bed. The identified safety device did not activate once the resident was transferred out of their mobility aide. PSW #104 adjusted the safety device which activated the alarm.

In an interview, the A-DOC indicated that they changed resident #002's identified safety device to another type as the previous device did not work properly.

After observations conducted, where resident #002's safety device did not work and staff interview with the A-DOC, the home did not comply with part (a) of CO #001.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee shall comply with this Act, the Local Health System Integration Act,
2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every
directive issued, order made or agreement entered into under this Act and those Acts. 2007,
c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23, to be implemented voluntarily.

Issued on this 15th day of July, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.