Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2020	2020_642698_0017	008062-20, 017564-20, 019820-20, 020368-20	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

ORALDEEN BROWN (698), HARSIMRAN KAUR (654)

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): October 20-23, 27, 2020. Additional off-site inspection activities were conducted on October 28-30, 2020.

The following intakes were completed during this inspection: Log/Critical Incident Systems (CIS) #s: 008062-20/C533-000003-20 (related to fall resulting in injury), 020368-20/2997-000007-20 and 017564-20/2997-000004-20 (related to unexpected death and multiple care areas); 019820-20/2997-000005-20 (related to alleged abuse).

During the course of the inspection, the inspectors made applicable observations such as dining, staff to resident and resident to resident interactions; conducted record reviews of
residents' health records and relevant policies and procedures.

PLEASE NOTE: A Written Notification related to LTCHA, 2007, c.8, s. 24(1), was identified in this inspection for non-compliance in late reporting log #019820-20/CIS #2997-000005-20 and was issued in a concurrent complaint inspection report #2020_642698_0016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs) and Dietary Manager.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided for falls prevention and management.

A resident experienced a fall that caused an injury. The plan of care indicated that a safety device was used due to moderate fall risk, impaired mobility and unsteady gait. During an observation, the safety device was not in place.

Two PSWs confirmed that the resident should have had the safety device and did not have it for the last one to two months. The resident required limited assistance with one staff for transfers and mobility but did not like to call the staff for assistance. The Director of Care (DOC) acknowledged that the resident should have had the the safety device due to their history of falls as per their plan of care.

Sources: resident observation, electronic record review, CIS report, and staff interviews. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident’s care needs for dietary requirements were changed.

The resident was assessed by the home’s dietitian and required an intervention. The resident’s plan of care did not indicate the intervention. A PSW provided the resident with the intervention as they were aware it was required.

The dietary manager and an RPN stated that the resident was required to have the intervention, and it was not updated on the plan of care by the dietitian. DOC acknowledged that the resident's plan of care should have been revised as per the dietitian assessment to have this available to the nursing staff.

Sources: Electronic record review, CIS report, and staff interviews. [s. 6. (10) (b)]

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 that the care set out in the plan of care is provided to a resident as specified in the plan; that a resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 25th day of November, 2020

[redacted]

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

Original report signed by the inspector.