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 17, 2020	2020_642698_0016	017959-20, 018019-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 16, 20-23, 2020. Additional off-site inspection activities were conducted on October 28-30, 2020.

During the course of the inspection, the following intakes were inspected.

Intake log #018019-20 related to abuse;
Intake log #017959-20 related to residents' bill of rights;

PLEASE NOTE: A Written Notification related to LTCHA, 2007, c.8, s. 24(1) for late reporting was identified in a concurrent Critical Incident System (CIS) inspection #2020_642698_0017 and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Registered Practical Nurse (RPN), Activation Aid, resident and family.

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

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her participation in decision-making respected.

The licensee did not fully respect and promote the resident's right to participate in decision-making when they denied visitation from a family member. The home contacted the resident's Substitute Decision Maker (SDM) to get consent instead of consulting with the resident first.

During an interview with the resident, they indicated that they had visitors in the past and was informed by the home that a family member had intentions of taking them out of the facility for a visit.

During an interview with the ED, they acknowledged that they did not consult with the resident prior to denying their visitor access. Instead, they contacted the SDM to obtain consent for visitation and denied visitor access to the resident.

Sources: observations, electronic records, paper chart (SDM documents), complaint intake, resident/staff/family interviews. [s. 3. (1) 9.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident or abuse of a resident by anyone is immediately investigated.

A complaint was submitted to the Ministry relating to an alleged abuse towards a resident. The home was made aware of the same allegation 21 days prior, when detectives arrived at the home and notified them of the alleged abuse. The detectives informed the home that no investigation was conducted and there was no allegation of abuse involving the home's staff. The home did not conduct their own investigation of the allegations. A CIS was submitted after the home had a telephone conversation with an inspector during an inquiry.

During an interview with the Executive Director (ED), they indicated that upon becoming aware of the allegations, they did not investigate the alleged abuse due to the fact that it did not involve a staff member inside the home.

Sources: CIS report and staff interview. [s. 23. (1) (a) (i)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that abuse of a resident by anyone that resulted in harm or risk of harm was immediately reported; the suspicion and the information upon which it was based to the Director.

The home became aware of an allegation of abuse towards a resident when detectives arrived at the home to investigate. The allegation was unfounded by the detectives. The home did not submit a CIS upon becoming aware of the suspicion of abuse.

During an interview with the Executive Director (ED), they indicated that upon becoming aware of the allegations, they did not believe it was necessary to submit a report to the Ministry when it did not involve their staff. The ED indicated that after speaking with an inspector they realized that a CIS should have been submitted and did so 21 days later.

Sources: CIS report, electronic records, observations and resident/family/staff interviews. [s. 24. (1)]

Issued on this 20th day of November, 2020

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

Original report signed by the inspector.