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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2022	2022_899609_0006	009590-21, 012835-21, 014098-21, 014768-21, 015209-21, 015685-21	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

CHAD CAMPS (609)

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): March 21-25, March 28-31 and April 1, 2022.

The following intakes were inspected upon during this Complaint inspection:

-Six intakes related to allegations of abuse, neglect and improper care of a resident.

A Critical Incident System (CIS) inspection #2022_899609_0007 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents and family of residents, the Administrator, Director of Care (DOC), Manager of Resident Assessment Instrument (RAI) and Mandatory Programs, Environmental Services Manager, Nutrition Manager, Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Scheduler, Cook and Screeners.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of resident care and services, observed staff and resident interactions, observed infection control practices, reviewed relevant health care and video footage, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was treated in a way that fully respected the resident's dignity.

The Inspector observed a Registered Practical Nurse (RPN) take away a bowl of food from a resident who was attempting to feed themselves. The RPN was also observed yelling at the resident.

The RPN acknowledged that they yelled at the resident and verified that their actions were "not right", that they did not respect the resident's dignity and that they should have spoken "nicely" to the resident.

The Director of Care (DOC) indicated that the RPN's actions towards the resident did not respect their dignity.

The home's failure to ensure that the resident's dignity was fully respected presented minimal risk of harm to the resident, who gave no indication that they were aware of the RPN's action.

Sources: Observations of a meal service, interviews with an RPN and the DOC, the home's policy titled "Residents' Bill of Rights and Responsibilities" no revision date. [s. 3. (1) 1.]

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 a resident is treated in a way that respects their dignity, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A Personal Support Worker (PSW) was observed providing care to a resident. The PSW continued to provide care despite the resident displaying responsive behaviours. The PSW finished providing care after they improperly transferred the resident.

The resident's plan of care at the time of the incident outlined interventions to be implemented for care, transfers and/or when the resident was displaying responsive behaviours.

The PSW admitted that they did not implement the resident's interventions outlined in the resident's plan of care when they provided care.

The DOC and Administrator verified that the PSW did not follow the resident's plan of care, which caused an increase in the resident's responsive behaviours and agreed that the manner which the PSW transferred the resident was "not acceptable".

The home's failure to provide the resident with the care as specified in the resident's plan presented risk to the resident by escalating the resident's responsive behaviours during care while improperly transferring them.

Sources: video footage of a resident, a resident's health care records and plan of care report, the home's policy titled "Resident Care Planning" no revision date, interviews with PSW staff, DOC and Administrator. [s. 6. (7)]

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 care set out in the plans of care is provided to residents as specified in the plans, to be implemented voluntarily.

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect that abuse and/or neglect of a resident occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A) A Critical Incident System (CIS) report was submitted by the home to the Director, which outlined allegations of neglect of a resident. The home became aware of the allegations via email to the Manager of Resident Assessment Instrument (RAI) and Mandatory Programs.

The Manager of RAI and Mandatory Programs verified that they had received the email outlining the allegations of neglect and verified that the allegations were reported late to the Director by nine days. The Manager of RAI and Mandatory Programs verified that the allegations should have been immediately reported to the Director.

B) A CIS report was submitted by the home to the Director, which outlined allegations of neglect of a resident. The home became aware of the allegations via email to the Administrator.

The Administrator verified that they had received the email outlining the allegations of neglect and acknowledged that they should have immediately reported the allegations to the Director. The Administrator verified they reported the allegations two days late to the Director.

The home’s failure to ensure that the Director was immediately notified of allegations of abuse and/or neglect of a resident presented no harm to the resident.

Sources: Two CIS reports, the home’s policy titled “Critical Incident and Mandatory Reporting of Certain Matters” no revision date, interviews with the Administrator and Manager of RAI and Mandatory Programs. [s. 24. (1)]

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 anyone who has reasonable grounds to suspect that abuse and/or neglect of a resident occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that a hand hygiene (HH) program was in place in accordance with the Ontario evidenced-based HH program, “Just Clean Your Hands” (JCYH) related to staff assisting residents with HH before meals.

On three separate days, the Inspector observed the a meal service in one of the home's dining rooms where HH was not provided or encouraged to residents before they ate their meals.

The home’s DOC and PSW staff verified that residents were to be provided or encouraged with HH before they ate their meals. The Infection Prevention and Control (IPAC) Lead for the home acknowledged that HH for residents before meals was being missed.

However, a review of the home’s HH program failed to mention that residents required HH be provided or encouraged before meals and no reference that the HH program was based on the required JCYH program. The IPAC Lead acknowledged they were unaware of what the home's HH program was based on.

The home’s failure to ensure the HH program was in accordance with the JCYH evidenced-based program presented a minimal risk to residents related to the possible transmission of disease-causing organisms that may have been on their hands.

Sources: Observations of three meal services, interviews with the DOC, IPAC Lead and PSW staff, the home’s policy titled “Hand Hygiene” no revision date and the “Just Clean Your Hands Implementation Guide Ontario’s step-by-step guide to implementing a hand hygiene program in your long-term care home” Catalogue #011816 3M September 2009. [s. 229. (9)]

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 a HH program is in place in accordance with the Ontario evidenced-based HH program JCYH, related to staff assisting residents with HH before meals, to be implemented voluntarily.

Issued on this 6th day of May, 2022

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

Original report signed by the inspector.