Ontario

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

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
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Original Public Report

Report Issue Date: February 8, 2023
Inspection Number: 2023-1496-0002
Inspection Type: Critical Incident System (CIS) Complaint
Licensee: Kristus Darzs Latvian Home
Long Term Care Home and City: Kristus Darzs Latvian Home, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.02.08 10:56:05 -05'00'

Additional Inspector(s)
Inspector Cindy Ma (000711) was present in the inspection.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 23-27, 31, February 2, 3, 2023

The following intake(s) were inspected:

- Intake # 00015451 (CIS #2997-000031-22) related to a fall;
- Intake # 00016951 (Complaint) related to the plan of care, and the management of falls, pain and medications.

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

Infection Prevention and Control
Resident Care and Support Services
Medication Management
Falls Prevention and Management
Safe and Secure Home

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INSPECTION RESULTS

WRITTEN NOTIFICATION: DOORS IN THE HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary

The tub room in one resident home area (RHA) was open and unlocked. There were mobile residents in the vicinity at the time of the observation.

A Registered Nurse (RN) verified that residents were not allowed in the tub room unless supervised by staff, and that the room had to be closed and locked for resident safety.

There was a risk of injury to the mobile residents in the vicinity if they had attempted to enter the tub room unsupervised.

Sources: RHA observation; and interview with the RN. [665]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 6 (7)

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 related to falls.

Rationale and Summary

The home submitted a CIS report to the Ministry of Long-Term Care (MLTC) related to a fall that resulted in a significant change in the resident's status.

The resident was at risk for falls and the care plan directed staff to ensure an intervention was in place.

The resident was observed without the intervention in place. A Registered Practical Nurse (RPN) verified that the intervention was not in place as per the plan of care.

The resident was at risk of not receiving timely assistance when the intervention was not provided.

Sources: Resident observation; record review of the resident's clinical records, and CIS #2997-000031-22 report; and interviews with the RPN and other staff. [665]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) (2)

The licensee has failed to ensure that the infection prevention and control (IPAC) lead designated under this section worked regularly in that position on site at the home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary

The home's licensed bed capacity was 100 beds. For the 16-week period between October 3, 2022, to January 22, 2023, there were nine weeks where the IPAC Lead did not work the required number of hours per week of 26.25 hours.

The IPAC Lead #102 confirmed that they did not work regularly in the position for at least 26.25 hours per week.

There was a risk that the home's IPAC program may not be as effective to ensure the safety of residents, staff, and caregivers when the IPAC Lead did not work at least 26.25 hours per week.

Sources: Review of Employee timesheets and staff schedules; and interviews with the IPAC Lead and other staff. [665]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

A) The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, the proper use of personal protective equipment (PPE), including appropriate application as required by Additional Requirement 9.1 (d) under the IPAC standard.

Rationale and Summary

A Screener was observed in the screening area with their surgical mask not covering their nose and mouth.

The home's policy indicated that masks should securely cover the nose and mouth.

The Screener and IPAC Lead confirmed that the surgical mask was not worn appropriately.

There was a risk of infection transmission to the Screener, staff, and visitors when the surgical mask was not worn appropriately.

Sources: Staff observation; review of home's policy titled, Routine Practices and Additional Precautions and IPAC Standard for Long-Term Care Homes April 2022; and interviews with the Screener, IPAC Lead and other staff. [665]

B) The home has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, support for residents to perform hand hygiene prior to receiving snacks as required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary

A Personal Support Worker (PSW) did not assist a resident with hand hygiene prior to providing them their snack. The resident was able to feed themselves.

The PSW indicated they were supposed to assist the resident with hand hygiene prior to their snack but did not.

The IPAC Lead indicated that all residents were to be assisted with hand hygiene prior to meals and snacks as per their hand hygiene program.

There was a risk of infection transmission to the resident when they were not assisted with hand hygiene prior to their snack.

Sources: Resident care observations; review of IPAC Standard for Long-Term Care Homes April 2022, and the resident's clinical records; and interviews with the PSW, IPAC Lead and other staff. [665]

C) The home has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, that the hand hygiene program included 70-90% alcohol-based hand rub (ABHR) as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

During the initial tour of the home, six bottles of expired ABHR were observed. Five expired Spectrum Hand Sanitizer Foam ABHR bottles with an expiration date of November 2022, were at the main entrance and screening area and one bottle of Live Clean ABHR was in one RHA which had expired in 2022.

The IPAC Lead indicated that the expired ABHR should not have been used in the home as it decreased the ABHR's effectiveness.

The use of expired ABHR reduced the effectiveness of the ABHR used in the home's hand hygiene program.

Sources: Observations on January 23, 2023; review of ABHR labels - Spectrum Hand Sanitizer Foam and Live Clean, and IPAC Standard for Long-Term Care Homes April 2022; and interviews with IPAC Lead and other staff. [665]