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
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Original Public Report

Report Issue Date: October 7, 2024
Inspection Number: 2024-1496-0004
Inspection Type: Complaint Critical Incident
Licensee: Kristus Darzs Latvian Home
Long Term Care Home and City: Kristus Darzs Latvian Home, Woodbridge

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 18-20, 23-27, 2024.

The following intakes were inspected:
• Intake: #00119774 - [Critical Incident (CI): 2997-000010-24] – was related to falls prevention and management
• Intake: #00121053 - [CI: 2997-000012-24] – was related to an injury of unknown cause

The following intake was inspected in this Complaints inspection:
• Intake: #00119758 - was related to plan of care, falls prevention and management and safe and secure home

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

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the planned care for a resident was set out to include a specified equipment as a fall intervention.

Rationale and Summary
A specified equipment was observed placed beside a resident's bed.

The resident's plan of care did not indicate the use of the specified equipment as part of their falls management interventions.

Two Registered Nurses (RNs) confirmed that the use of the specified equipment was not written in the resident's plan of care as part of the fall management interventions.

Two RNs and the Assistant Director of Care (ADOC) stated that the resident's care plan should have included the use of the specified equipment as part of the resident's fall management interventions.

After being notified, an RN updated the resident's care plan to include utilizing a specified equipment part of the resident's fall management interventions.

There was a low risk to the resident when the planned care was not set out in their care plan since the care provided adequately met the resident's current needs.

Sources: Resident's clinical records; Inspector's observation; interviews with staff.

Date Remedy Implemented: September 20, 2024

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were be kept locked to restrict unsupervised access to the areas by residents.

Rationale and Summary

During a tour of the home's basement lobby, a door leading to a non-resident area from the basement lobby was observed to be unlocked. Inside the non-residential area, it was observed that there were two storage rooms that included hazardous cleaning products, and those doors were open and unsupervised by staff.

A Maintenance Worker (MW) stated that the door leading to the non-residential area had not been working properly due to issue with the door closer.

The MW, Director of Care (DOC) and the Environmental Service Manager indicated that the door leading to non-residential area should have been locked to restrict unsupervised access to the area by residents.

Failing to ensure that doors were kept locked when unsupervised posed a risk to the safety of residents.

Sources: Inspector's observation; and interviews with staff.