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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Public Report

Report Issue Date: January 16, 2025

Inspection Number: 2025-1496-0001

Inspection Type:
Critical Incident

Licensee: Kristus Darzs Latvian Home

Long Term Care Home and City: Kristus Darzs Latvian Home, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8, 9, 10, 13, 14, 15, 16, 2025

The following intake(s) were inspected:

- Intake: #00128539 - Critical Incident System (CIS) 2997-000014-24 - related to Fall Prevention and Management
- Intake: #00130156 - CIS 2997-000015-24; Intake: #00134241 - CIS 2997-000017-24 - related to Outbreak Management
- Intake: #00131914 -CIS 2997-000016-24 - related to Resident Care and Support Services

The following intake was completed:

- Intake: #00126402 - CIS 2997-000013-24 - related to Fall Prevention and Management.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2)

The licensee has failed to ensure that on every shift, resident's symptoms indicating the presence of infection were monitored.

Two residents were confirmed cases in the home's outbreak and were on additional precautions. Their symptoms of infection were not monitored every shift.

Sources: Review of residents' clinical records; and interview with the IPAC Lead #102.

WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed of an outbreak when it was declared by York Region Public Health (YRPH).

Source: Critical incident report (CIS) #2997-000015-24, and interview with the IPAC Lead #102.

WRITTEN NOTIFICATION: CMOH AND MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that Recommendation for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health was followed in the home. In accordance with these recommendations the licensee was required to conduct weekly Infection Prevention and Control (IPAC)

audits during a COVID-19 outbreak.

The home was in a COVID-19 outbreak for one month. The IPAC Lead #102 confirmed that a weekly IPAC audit was missed during this period.

Sources: Recommendation for Outbreak Prevention and Control in Institutions and Congregate Living Settings effective October 2024, Review of home's COVID-19 self assessment IPAC audits, interview with IPAC Lead #102.