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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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: April 17, 2025
Inspection Number: 2025-1496-0002
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): April 14, 15, 16, 17, 2025

The following intake(s) were inspected:

- Intake: #00139461 related to improper transter of a resident and;
- Intake: #00140616 related to a fall with injury.

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that two Personal Support Workers (PSWs) used safe transferring devices when they assisted a resident.

The resident was assessed by the Physiotherapist (PT) to require a specific device for transfers when they experienced a health condition. The PSWs used a different device to transfer the resident when they experienced the health condition. The resident experienced a negative health outcome afterwards.

The Physiotherapist (PT) indicated that the device used was not safe to transfer the resident as it placed the resident at risk of injury.

Sources: Review of Critical Incident Report, PT assessments, resident's plan of care; and interviews with two PSWs, the PT and other staff.