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

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Public Report

Report Issue Date: June 26, 2025
Inspection Number: 2025-1453-0003
Inspection Type: Critical Incident Follow up
Licensee: Broadview Foundation
Long Term Care Home and City: Chester Village, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17, 18, 20, 23 - 26, 2025.

The following intake(s) were inspected:

- Intake: #00145180 - Follow-up #1: CO #001, 2025-1453-0002, FLTCA, 2021 - s. 6 (7) Duty of licensee to comply with plan.
- Intake: #00145181 - Follow-up #1: CO #002, 2025-1453-0002, O. Reg. 246/22 - s. 102 (2) (b) Infection prevention and control program.
- Intake: #00146667 - Critical Incident (CI) 2970-000011-25 - related to a disease outbreak.
- Intake: #00146874 - CI 2970-000012-25 - related to a resident fall resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1453-0002 related to FLTCA, 2021, s. 6 (7)
Order #002 from Inspection #2025-1453-0002 related to O. Reg. 246/22, s. 102 (2) (b)

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care provided clear directions to staff. On a specified date, a resident had a fall that resulted in injury and subsequent hospitalization. The resident's plan of care at the time of the incident had conflicting directions regarding a fall intervention, neither of which were followed.

Sources: Resident clinical records; Home's investigation notes; and interviews with the home's staff.

WRITTEN NOTIFICATION: Hazardous substances

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

A housekeeper's cart was left unattended in a resident home area, and a compartment that stored cleaning chemicals was not locked. The Housekeeper acknowledged that the cart should have been locked due to a risk of resident's accessing the chemicals inside and potentially harming themselves.

Sources: Observation; interview with the home's staff.