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: August 14, 2025
Inspection Number: 2025-1453-0004
Inspection Type:
Complaint
Critical Incident

Licensee: Broadview Foundation
Long Term Care Home and City: Chester Village, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6-8, 11, 12 and 14, 2025.
The inspection occurred offsite on the following date(s): August 13, 2025.

The following complaint intake was inspected:

- Intake: #00151664 was related to improper care of a resident and an allegation of staff-to-resident abuse.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00148028/ CI #2970-000015-25 was related to an allegation of staff-to-resident abuse.
- Intake: #00150451 / CI #2970-000016-25 was related to falls prevention and management.
- Intake: #00153815/ CI #2970-000020-25 was related to an injury due to an unknown cause.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
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 resident's written plan of care included the planned care for the resident.

A fall prevention and injury mitigation intervention was initiated for a resident following a fall incident. However, this intervention had not been documented in the resident's written plan of care at the time of observations. The care plan was updated, after the omission was identified and brought to the attention of the home.

Sources: Review of resident's clinical records, Critical Incident System (CIS), and interviews with staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the resident's fall intervention was in place as

specified in their plan of care.

The inspector observed the resident without the appropriate fall intervention in place. According to the resident's plan of care, staff were expected to ensure the fall intervention was in place. The Personal Support Worker (PSW) confirmed the intervention was not in place and acknowledged that it should have been as per their plan of care.

Sources: Observations, the resident's plan of care, and interviews with the PSW and Director of Care (DOC).

The licensee has failed to provide care as set out in the plan of care related to toileting for the resident.

The care plan indicated that the resident required a specific level of assistance for toileting. However the home's internal investigation confirmed that the indicated level of assistance was not provided by a PSW. The PSW acknowledged that they did not follow the resident's care plan regarding toileting.

Sources: Resident's clinical records, review of incident investigation notes, and interview with the PSW.

WRITTEN NOTIFICATION: SAFE TRANSFER AND POSITIONING

NC #003 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 the PSW used safe transferring and positioning devices and techniques when assisting the resident.

The home's Lift / Transfers-Mechanical Policy stated that a specific number of staff must be present when using a specific equipment to transfer a resident. The home's internal investigation confirmed that the resident's transfer was performed without the indicated number of staff when the PSW used the transfer equipment. The PSW

acknowledged that they performed an unsafe transfer.

Sources: Resident's clinical records, review of incident investigation notes, Lift / Transfers-Mechanical Policy and interview with the PSW.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that staff complied with the home's falls prevention and management program when a resident sustained a fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

The home's Falls Prevention policy specified that, following a fall, registered staff must complete an assessment using a clinically appropriate tool. However, the post- fall assessment was not completed following a resident's fall incident.

Sources: Fall Prevention and Management Program Policy, the resident's clinical records, interviews with the Registered Practical Nurse and DOC.

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

The licensee has failed to ensure that the water temperature did not exceed 49 degrees Celsius.

Hot water temperatures on the unit were documented by registered staff as exceeding 49 degrees Celsius on multiple occasions. The Environmental Services Manager (EVSM) acknowledged that staff did not report the elevated temperatures, placing residents at risk of scalding.

Sources: Hot water temperature records and interview with the EVSM.

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (h)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

The licensee has failed to take immediate action when the water temperatures exceeded 49 degrees Celsius.

Hot water temperatures on the unit were documented by registered staff as exceeding 49°C on multiple occasions. Despite these readings, no corrective action was taken by the home. The EVSM confirmed that no steps were taken to address the elevated water

temperatures.

Sources: Hot water temperature records and interview with the EVSM.