Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 25, 2015	2015_398605_0006	T-1649-15	Resident Quality Inspection

Licensee/Titulaire de permis

BROADVIEW FOUNDATION
3555 DANFORTH AVENUE TORONTO ON M1L 1E3

Long-Term Care Home/Foyer de soins de longue durée

CHESTER VILLAGE
3555 DANFORTH AVENUE TORONTO ON M1L 1E3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SARAH KENNEDY (605), SLAVICA VUCKO (210), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 13, 16, 17, 18, 19, 20, 23, 2015.

The following complaint intake was inspected: T-001420-14.
The following critical incident intakes were inspected: T-000428-13 and T-000257-14.

During the course of the inspection, the inspector(s) spoke with the chief executive officer (CEO), director of care (DOC), assistant director of care (ADOC), nurse manager, resident assessment instrument - minimum data set (RAI-MDS) coordinator, environmental services manager (ESM), resident support services manager (RSSM), registered dietitian (RD), registered nursing staff, personal support workers (PSWs), janitor, dietary aide, residents, family members and substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of resident care, staff-resident interactions, reviewed the home's records, policies and procedures, Resident Council and Family Council minutes, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

9 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is treated with courtesy and respect.

Review of a Critical Incident (CI) report submitted by the home revealed that an identified resident had reported to a staff member that he/she is scared to ask for help because an identified PSW yells at him/her and can provide rough care. No physical injuries were documented.

Review of the home's investigation notes revealed that two additional residents stated the identified PSW can be "nasty" and provide hurried/rough care. The investigation concluded that the identified PSW "treated the identified resident and others in a manner that is deemed to be in violation of the Residents Rights, is abusive in nature and can be characterized as bullying, rude, disrespectful and rough handling and complete disregard for the resident's rights and wishes".

Interviews with the DOC confirmed that progressive disciplinary action was taken in response to the allegations and residents were not treated with courtesy and respect. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is treated with courtesy and respect, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Interview with an identified PSW indicated that an identified resident has a responsive behaviour when personal care is given. The resident does not want to be wiped with a wet towel; instead he/she prefers being washed in the shower. When the resident has an incident with bowel movements and staff try to take him/her to the bathroom for personal care, the resident becomes resistive and even physical with staff. If the resident is taken to the shower for personal care he/she does not become resistive and care can be provided by one staff member. The identified PSW is aware that this approach is working well and is practiced by another PSW but it has not been shared with the registered

nursing staff in order for the written plan of care to be updated.

Review of the behaviour progress notes revealed that on an identified date, before lunch when the resident was taken to his/her room to be washed from feces the resident became combative, shouted and was hitting. After care the resident refused to go to the dining room. On another occasion, a PSW reported that the resident was physically and verbally aggressive during evening care. The resident has also been resistive to care as evidenced by yelling at staff and throwing away his/her incontinent product towards a PSW. The resident was discouraged of his/her behaviour and re-approached by two staff to provide care. Staff were only able to provide personal care and change his/her incontinent product but the resident refused to have his/her pants and top changed.

Interviews with an identified registered nursing staff and the ADOC confirmed that not all strategies that staff use to deal with the responsive behaviour of the identified resident are communicated and documented in the written plan of care in order to be used consistently by all staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the written plan of care for an identified resident indicated "ensure dentures are applied before each meal and removed after meals and kept inside the treatment room. Staff to provide total feeding and to be fed slowly".

During an observation performed throughout the inspection it was noted that this resident had loose dentures in his/her mouth and he/she was playing with the lower denture (turning it around in his/her mouth with his/her tongue).

Interview with an identified PSW indicated he/she would remove the dentures after the meal, but sometimes the resident does not allow staff to remove the dentures. Furthermore he/she stated that he/she took the dentures from the nurse in the morning in order to apply them before breakfast but he/she did not remove them after breakfast and give them to the nurse to be kept in the treatment room until lunch time. The identified PSW did not report to the registered nursing staff that the dentures stayed in the residents mouth between meals and stated that he/she used "common sense" to monitor the resident.

Interview with the identified registered nursing staff indicated staff did not remove the

dentures after breakfast, and the expectation is if the resident refuses to give the dentures to the PSW, that this must be reported to the registered nursing staff.

Interviews with the identified PSW and the identified registered nursing staff confirmed that the written plan of care was not being followed. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment is kept clean and sanitary.

It was observed during the inspection that a resident's wheelchair was soiled with white particles. It was also observed that another resident's wheelchair had sticky spots on the wheelchair arms.

Interviews conducted with two identified registered staff members confirmed that the identified ambulatory equipment continued to be soiled over the course of a few days and in addition one resident's wheelchair had dried food on the seat cushion.

Review of the 'Wheelchair Cleaning' schedule on Point of Care (POC) revealed that one resident's wheelchair was supposed to be cleaned the day before the equipment was found soiled by the inspector. Interview with a Nurse Manager indicated that the expectation is for staff to follow the wheelchair cleaning schedule and to clean equipment as needed if found unclean.

Observation, record review and interviews with the identified staff members confirmed that the wheelchairs for the identified residents were not kept clean and sanitary. [s. 15. (2) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed used by residents.

On an identified date, the inspector observed the call bell cord in an identified resident's room room was broken and the resident-staff communication and response system was not able to be activated. Interview with an identified PSW revealed that he/she was not aware of the broken call bell cord.

Prior to the completion of the inspection, the inspector observed the above mentioned call bell cord was replaced and it was functioning. [s. 17. (1) (d)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident is assessed.

Review of a residents health record revealed that the resident had fall incidents on four identified dates. Review of the resident's health record also revealed that the post-fall assessments were not completed for the resident after three of the identified falls.

Review of the home's Fall Prevention and Management Program policy, index I.D.: RCSM-E-15, revised on March 4, 2014, states that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls.

Interview with the DOC confirmed that the post fall assessment should be completed after every fall. Review of the clinical records and an interview with the DOC confirmed that the post fall assessment was not completed after all of the identified residents falls. [s. 49. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle is reviewed by the Resident's Council.

Interview with an identified member of the Resident's Council revealed that the menu cycle is not reviewed by the Resident's Council. The member stated that the menu cycle is reviewed by the Food Committee and that not all members of the Resident's Council attend the Food Committee meetings.

Interview with an identified staff member confirmed that he/she is aware that the menu cycle should be reviewed by the Resident's Council but it was only reviewed by the Food Committee. [s. 71. (1) (f)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Resident's Council.

Interview with an identified member of the Resident's Council revealed that the dining and snack service does not include a review of meal and snack times by the Resident's Council. The member stated that the meal and snack times are reviewed by the Food Committee and that not all members of the Resident's Council attend the Food Committee meetings.

Interview with an identified staff member confirmed that he/she is aware that the meal and snack times should be reviewed by the Resident's Council but was only reviewed by the Food Committee. [s. 73. (1) 2.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey.

Interview with an identified member of the Family Council revealed that the home does not consult with the Family Council on how to develop and carry out the survey.

Interview with management revealed that he/she was able to provide proof of consulting the family council on how to develop and carry out the survey in 2013, but not in 2014. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, and that is secure and locked.

On an identified date, the inspector observed a bottle of prescribed medication with an identified residents name on it in the resident fridge on an identified unit.

Interviews with an identified registered nursing staff and the DOC indicated that the resident’s fridge is for storing resident’s food only and is accessible by staff, residents and family members. It was confirmed that medications should not be kept in any of the resident fridges. [s. 129. (1) (a)]

Issued on this 20th day of April, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.