Ontario

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2019	2019_630589_0004	015007-17, 022605-17, 024369-17, 027370-17, 028752-17, 007096-18	Critical Incident System

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

JOANNE ZAHUR (589), GORDANA KRSTEVSKA (600), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 1, 4, 5, 6 (off-site), 7, 8, 11, 12 (off-site), 13, 14, 15, and 20 (off-site), 2019.

The following intakes were completed during this inspection:
-log #015007-17 related to falls prevention and an unsafe transfer,
-log #027370-17 related to an unsafe transfer, and
-logs #028752-17, #007096-18, #022605-17, and log #024369-17 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Physiotherapist (PT), Registered Nurse (RN), Registered Practical Nurse (RPN), Nurse Manager (NM),Personal Support Worker (PSW), substitute decision maker (SDM), and residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health
records, the home's internal investigation notes, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Légende 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system (CIS) report for an incident that indicated when staff #108 and staff #110 were providing care to resident #004 they sustained an injury. Upon being positioned in bed, staff #108 noted resident #004's clothing was soiled which was then reported to staff #109 and staff #116.

A review of the care plan in place at the time of the incident indicated resident #004 required two staff to provide care. The care plan also indicated resident #004 required an identified type of protective clothing related to risk for injury.

Resident #004 no longer resides in the home therefore an interview was not conducted. Resident #004's spouse continues to reside in the home and during a conversation with the inspector, they could not recall the above mentioned incident.

In an interview, staff #109 stated that upon entering resident #004's room they noted the protective clothing was soiled due an injury and then notified staff #116 to complete an assessment.

In an interview, staff #116 stated upon arriving in resident #004's room they removed the protective clothing, noting an injury. Care was provided and a treatment was applied. Staff #116 instructed staff #109 to transfer resident #004 to hospital for further assessment. Both staff #109 and staff #116 stated the injury appeared to be as a result of a recent incident. Staff #109 and staff #116 further stated that staff #108 had informed them resident #004 must have struck themselves on the bed during care causing the injury

A telephone interview was conducted as staff #108 was contracted to the home through an agency. During the telephone interview, staff #108 stated they were not sure if the injury had happened during care as identified in the CIS report, in fact they were not sure if maybe this had happened earlier in their shift or even on the previous shift. Staff #108 was hesitant to acknowledge that resident #004's had sustained an injury even though that is what they had reported to staff #109 and staff #116 at the time of the incident.

In an interview, staff #112 had provided care to resident #004 on the previous shift, had applied the protective clothing and did not note any injuries at that time.

In an interview, staff #115 was hesitant to acknowledge an unsafe transfer had occurred citing resident #004's risk for injury and the possibility of a spontaneous injury having

occurred. [s. 36.]

2. The MOHLTC received a CIS report indicating that staff #114 had transferred resident #005 using a mobility transfer aid unassisted. During the transfer, the transfer aid became unattached resulting in resident #005 falling, landing on the floor, and sustaining an injury that required a transfer to hospital. Upon re-admission to the home, resident #005 was stable and within their previous baseline status.

A review of resident #005's plan of care in place at the time of the incident indicated that resident #005 was totally dependent and required a two person physical assist for care related to transferring.

A review of the home's investigation notes indicated that staff #114 had stated everyone else was busy and that they needed to get resident #005 up for their meal so they completed the care unassisted. During care resident #005 fell to the floor sustaining an injury.

During an interview, staff #114 acknowledged they had received education and were fully aware that two staff must be present when using a mobility aid to transfer a resident. Staff #114 further stated that on that day, they could not find another staff member to assist so they proceeded to provide care unassisted. While the mobility aid was in use, it became unsecure resulting in resident #005 falling to the floor and sustaining an injury. Staff #114 acknowledged they had conducted an unsafe transfer.

During an interview, staff #115 acknowledged that staff #114 had conducted an unsafe transfer when assisting resident #005.

The severity of this finding was a level 3, indicating actual harm/risk. The scope was a level 2, indicating a pattern. A review of the home's compliance history was a level 2, indicating previous unrelated non compliances. According to the judgement matrix, a compliance order (CO) is warranted, however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to unsafe transferring has been addressed and rectified by the home. A written notification (WN) is being issued. [s. 36.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

For the purposes of the definition of "significant change" in section 3.1 of the Ontario Regulation 79/10, significant change means a major change in the resident's health condition that,
• will not resolve itself without further intervention,
• impacts on more than one aspect of the resident's health condition, and
• requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

A review of resident #007's progress notes indicated that on an identified date in December 2017, resident #007 had a fall and complained of discomfort. Resident #007 was transferred to hospital and was diagnosed with an injury.

In an interview, staff #107, identified as the person who had initiated the CIS report stated they recalled the incident but they were not present at the time in the home. They submitted the CIS report after they had a meeting with the management team and were then told to submit the CIS report, three days after the incident. After reviewing the "Reporting Requirements Tip Sheet", staff #107 acknowledged that the home should have submitted the CIS report on the identified date in December 2017, when it had been

determined that resident #007 had sustained an injury for which they were transferred to hospital resulting in a significant change in their health condition.

In an interview, staff #123 was reluctant to acknowledge that the home did not comply with the O. Reg. r. 107. (3). 4., elaborating that they were not aware of this CIS report, so they could not respond, and that maybe the home had wanted to observe resident #007 first to identify if their condition changed, and then submit the CIS report.

Staff #123 and staff #107 indicated they were not aware of the option to initiate a CIS report on-line or accessing the MOHLTC's after-hours emergency contact number as required by the MOHLTC, and amend a CIS report after they had determined more accurate information regarding resident #007's health status. After reviewing the decision tree with the inspector, staff #107 acknowledged they should have submitted the CIS report once they had been notified by the hospital of resident #007's change in condition. [s. 107. (3) 4.]

2. The MOHLTC received a CIS report on an identified date in March 2018 that indicated resident #008 had an incident that had caused an injury for which the resident was taken to hospital and which resulted in a significant change in the resident's condition.

A review of resident #008's progress notes indicated that on an identified date in March 2018, they had two falls. The first fall indicated there were no injuries identified. The post fall assessment completed after the second fall identified that resident #008 had sustained injuries. Over the next 72 hours resident #008's health status deteriorated and was transferred to hospital on the fourth day and admitted with an identified injury.

In an interview, staff #107, identified as the person who had initiated the CIS report stated they recalled the incident that had happened and were told by the management to submit the CIS report. Staff #107 acknowledged that the home should have submitted the CIS report on the identified date in March 2018, when they had been notified by the hospital of resident #008's injury that had resulted in a significant change in the resident's health condition.

In an interview, staff #123 was reluctant to acknowledge that the home had not complied with O. Reg. 79/10, r. 107. (3). 4., elaborating that maybe the home had wanted to observe the resident first to identify if the resident's condition changed before submitting a CIS report. [s. 107. (3) 4.]

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Issued on this 1st day of March, 2019

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

Original report signed by the inspector.