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
Jun 25, 2019	2019_777731_0020	006371-18, 007313-18	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

KRISTEN MURRAY (731)

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): June 17 and 18, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to Disease Outbreak
Critical Incident Log #006371-18 / CIS report #2970-000005-18
Critical Incident Log #007313-18 / CIS report #2970-000007-18

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), a Registered Nurse (RN), and Personal Support Workers (PSWs).

The inspector also observed residents and the care provided to them, resident rooms and common areas, reviewed health care records, and reviewed documentation related to the home's Critical Incident policy.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

On February 26, 2018, the home submitted Critical Incident System (CIS) report #2970-000005-18 to the Ministry of Health and Long-Term Care (MOHLTC) and on April2, 2018, the home submitted CIS report #2970-000007-18 to the MOHLTC, regarding separate incidents of disease outbreak, specifically, Acute Respiratory Illness (ARI) outbreaks.

A review of CIS report #2970-000005-18 indicated that the outbreak was declared by Public Health on February 23, 2018 and the home submitted the CIS report to the MOHLTC on February 26, 2018. A review of CIS report #2970-000007-18 indicated that the outbreak was declared by Public Health on April 1, 2018 and the home submitted the CIS report to the MOHLTC on April 2, 2018.

In an interview with the Director of Care (DOC) #101, when asked if they were familiar with the reporting requirements for reporting outbreaks to the Director, the DOC #101 stated yes and that they were to be reported immediately. When asked if CIS report #2970-000005-18 was submitted immediately at the onset of the outbreak, DOC #101 stated it was not. When asked if CIS report #2970-000007-18 was submitted immediately at the onset of the outbreak, DOC #101 stated it also was not.

A review of the home's policy "Critical Incident/Reportable Matters", number RCSM-E-45, last reviewed on December 13, 2018, stated in part that a disease outbreak was to be immediately reported to the Ministry of Health Director through the CIS or the after-hours phone number.

The licensee failed to ensure that the Director was immediately informed of two separate ARI outbreaks. [s. 107. (1) 5.]

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 Director is immediately informed of any outbreaks of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

Issued on this 4th day of July, 2019

[redacted]

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

Original report signed by the inspector.