Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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 rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 4, 2021 | 2020_808535_0014 | 002683-20, 003245-20, 016568-20 | Complaint |

### 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

VERON ASH (535)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): November 23, 24, 25, 26, 27, 2020, off-site December 2, 3, 9, 10, 11, 17, 2020.**

**The following intakes were completed during this inspection:**

**Log#002683-20 was related to follow up CO #001- Inspection #2020_530726_0002, s. 36;**
**Log#003245-20 was related to neglect and infections; and**
**Log #016568-20 was related to care concerns and naps.**

**NOTE: A Written Notification and Compliance Order related to LTCHA, s. 6 (7) was identified in a concurrent inspection #2020_808535_0015 (Log #014551-20, CIS#2970-000009-20 and log #019076-20, CI #970-000012-20) and issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Nurse Managers (NM) the Physiotherapist (PT), Registered Dietitian (RD), Social Worker (SW), Resident Assessment Instrument (RAI) Coordinator, registered staff (RN/RPN), personal support workers (PSW) and substitute decision-maker.**

**During the course of the inspection, the inspector conducted observations of resident home areas and staff to resident interactions, reviewed clinical health records, treatment and medication administration records, staffing schedule, internal investigation notes and home's policies and procedures.**
**support workers.**

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

**Critical Incident Response**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **8 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 36. | CO #001 | 2020_530726_0002 | 535 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the resident was free from neglect by the licensee or

staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding resident care concerns including neglect.

Over an identified period of two months, the resident experienced a significant change in their health status - deterioration in their alertness, reduced intake and unstable vital signs.

During one particular shift, RPN #121 documented and verified during the interview, that the resident's vital signs and overall health status had deteriorated, but that they did not notify the registered nurse in charge (RN), the nurse manager (NM) in the building, nor the on-call physician. Their reason was because they decided to to endorse the information to the next shift nurse so that the primary physician would be called. RPN #121 acknowledged that in retrospect, they should have notified the RN, NM and on-call physician about the resident's change in status.

The resident's vital signs and clinical status were reviewed with Physician #119 and Nurse Manager (NM) #112 during separate interviews, and both agreed that the resident's clinical status should have been communicated to the team for further assessment and possible treatment.

During that same period the resident's intake was reduced, however registered staff did not complete a referral to the home's registered dietitian (RD) for assessment and possible treatment; and the physician was not consulted tor review medication related to hydration status.

The speech language pathologist (SLP) completed a swallowing assessment which revealed swallowing difficulty related to their diagnosis. During that same period, staff continued to feed the resident with no further referral to the RD or SLP, although the resident's alertness was decreased.

The resident's progress notes and an interview with RPN #109 verified that the resident

was transferred to hospital two shifts later after a discussion with the RN and physician.

The Inspector discussed the hospital's discharge summary with Physician #119, who acknowledged from the discharge summary that the resident had experienced complications related to their change in condition.

Sources: The resident's progress notes, E-MAR, MDS, Food and Fluid Records, SLP assessment, interviews with RPN #109 and #121, NM #112, DOC and Physician #119 and others. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

---

**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 the resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A complaint was received by the MLTC regarding care concerns for the resident including a previous fall incident.

The resident was left unsupervised by a PSW and they sustained a fall. The resident experienced an injury as a result of the unwitnessed fall.

PSW #118 verified that they left the resident unsupervised. RPN #111 attended and assessed the resident but did not notify the RN, NM or the PT that the resident had a fall and sustained an injury during their shift. The RPN further verified that they felt confident in their assessment of the resident, and therefore did not notify the RN or NM to further assess the resident's condition. They did not notify the on call physician, but notified the resident's substitution decision-maker (SDM).

Source : Resident's progress notes, post fall assessment, interview with PSW #118, RPN #111, PT and other interviews. [s. 6. (4) (a)]

2. Over a two months period, the resident's health status changed significantly with increased dependence for ADLs.

A review of the progress notes indicated that during their identified shift, RPN #121 assessed the resident and perform vital signs checks which indicated that the resident's overall health status was deteriorating. The RPN verified that they did not notify the registered nurse in charge (RN), the nurse manager (NM) in the building, nor the on-call physician. They decided it was best to endorse the information to the nurse on the next shift to contact the primary physician.

The resident's condition and vital signs were reviewed with primary Physician #119 and NM #112 during separate interviews, and both acknowledged that the resident's change in clinical status should have been communicated to the team for further assessment and possible treatment.

Sources: The resident's progress notes and MDS assessment, interviews with RPN #121, NM #112, Physician #119 and others. [s. 6. (4) (a)]

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

On an identified date, the resident was left unattended in the washroom by a PSW; and they slipped from the chair and fell to the floor. A review of the post fall assessment document indicated that the resident sustained an injury as a result of the unwitnessed

fall.

A review of the resident's plan of care indicated the resident required two-persons physical assistance for bathing. PSW #118 verified that they left the resident unsupervised.

Source : The resident's progress notes and written care plan, interview with PSW #118 and other. [s. 6. (7)]

4. A review of the resident's care plan indicated that the resident was not to have a specific gender PSW provide personal care. During an interview, PSW #116 stated that they unknowingly assisted the resident with personal care which required two PSWs, up to and including the summer months last year. The PSW stated that they were asked to help with personal care by the primary opposite gendered PSW; however they were not aware that the resident was not to have a specific gender PSW provide personal care or they would not have entered their room.

Sources: The resident's care plan, interviews with PSW #116 and others. [s. 6. (7)]

5. Clinical records indicated that the resident had a speech-language pathologist (SLP) assessment completed and their recommendation was for staff to provide cut up assistance for larger food items. A review of the progress notes indicated that the home's registered dietitian (RD) wrote an order for staff to cut the resident's food items in bite-size pieces during meals.

RPN #106, #111 and PSWs #107 and #108 stated in separate interviews that sometimes they would provide cut up assistance during meals if the resident was served hard foods on their such as chicken or meat during meals. However, they did not consistently cut up their food items, especially if the meal was a sandwich since that was soft and the resident was able to hold and eat the sandwich by themselves. The resident's intake records also indicated that sometimes the resident was provided with assistance and sometimes no assistance was provided during meals.

Sources: The resident's care plan, nutrition records and progress notes, SLP clinical consultation notes, interviews with PSWs #107 and #108 and others. [s. 6. (7)]

6. The resident's SDM requested that all direct caregivers should perform a specified intervention when providing direct and indirect care to the resident at all times.

A review of the resident's care plan indicated that this specific intervention was not included in the written care plan, however a sign was posted in the resident's room by NM #122 and the information was to have been communicated to all direct care staff. PSW #108 revealed during an interview that they removed all the signs posted in the resident's room. PSW #107 and #108 acknowledged during separate interviews that they did not perform that intervention consistently since they were not aware that the intent of the sign posted in the room meant to always perform that specific intervention during all contact with the resident.

Sources: The resident's electronic and printed care plan, interview with PSW #107 and #108 and others. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

---

**WN #3: 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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

The resident's SDM #130 stated that staff at the home engaged in multiple verbal altercations with them in the presence of the resident which caused the resident to become upset and subdued.

PSW #107 stated during an interview that they had engaged in a verbal altercation with the resident’s SDM in the resident’s room. During that altercation, raised voices were heard by other residents and family members on the resident home unit. RPN #106 stated that they also overheard the commotion and intervened to stop the altercation. PSW #107 verified that they had engaged in two verbal altercations with SDM #130 in the presence of the resident.

Nurse Manager #110 also verified that they had engaged in verbal altercations with SDM #130.

Sources: The resident’s progress notes, interviews with SDM, RPN #106, PSW #108, NM #110 and others. [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 the resident was fully respected and promoted the resident’s right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure when a resident exhibited altered skin integrity, including skin breakdown, they received immediate treatment and interventions to prevent infection as required.

A review of the resident's progress notes indicated that registered staff documented an area of altered skin integrity, and that a dressing change was completed. There was no further documentation related to the area in the PCC progress notes until weeks later, when RPN #106 assessed and took a sample from the area for testing.

The next day, Physician #119 assessed the area, ordered treatment and a referral to the wound care specialist. A few days later, RPN #106 documented that diagnostic test confirmed infection and medication was ordered for treatment.

The home's DOC verified that weekly skin assessments of the resident's altered skin integrity should have been initiated by the registered staff on the date of discovery of the skin breakdown, however the weekly skin assessment was not initiated by registered staff until weeks later.

Sources: The resident's PCC progress notes, E-TAR, weekly skin assessment, DOC e-mail documentation. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that the resident's altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home.

A review of the resident's progress notes and E-MARs over a two years period, indicated that they had several areas of altered skin integrity.

The DOC verified during an interview that registered staff should send a referral to the home's registered dietitian if a resident has altered skin integrity. There were no RD referral or assessment completed for the resident's altered skin integrity. The DOC verified that RD referrals were not completed.

Sources: The resident's progress notes and e-TAR, interview with DOC, email documentation by DOC. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that when the resident exhibited altered skin integrity, including skin breakdown, skin tears or wounds, they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the resident's progress notes over a two year period indicated that they sustained multiple altered skin integrity. There were nine skin integrity impairments listed with dates for review, however the list was not inclusive of all incidents of altered skin integrity documented by registered staff.

The DOC verified that registered staff should complete weekly skin assessment for all skin breakdowns. However, a review of the resident's progress notes and E-TAR indicated weekly skin assessments were not completed.

Sources: The resident's progress notes and E-TAR, interview with DOC, email documentation by DOC. [s. 50. (2) (b) (iv)]

***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 when a resident exhibited altered skin integrity, including skin breakdown, immediate treatment and interventions are received to prevent infection as required;***
***-to ensure that the resident altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home; and***
***-to ensure that when a resident exhibit altered skin integrity, including skin breakdown, skin tears or wounds, the resident was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home was immediately forwarded to the Director.

A complaint was received by the MLTC related to the resident's care concerns and the home's non-response to written complaints.

A review of the written complaints received by the MLTC indicated that SDM #130 submitted multiple written complaints to various team members related to resident care concerns; however letters indicating care concerns were not forwarded to the Director as indicated under s. 21 (1) of the LTCHA, 2007.

The home's CEO and DOC acknowledged during an interview that the letters were not forwarded to the Director because the home's policy indicated the following: anyone who wishes to lodge a 'written complaint' may do so in writing to the attention of the CEO or designate and clearly indicate as a subject line the words "written complaints" so that it is understood. The home's policy was not in alignment with s. 21 (1) of the LTCHA, 2007.

Sources: LTCHA, 2007, the home's Complaint Policy #ADM-VI-18 (review date: September 6, 2019), interview with the home's DOC and CEO. [s. 22. (1)]

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to the resident's treatment regime and personal support were documented.

A complaint was received by the MLTC related to providing the resident with a treatment regime ordered by their external clinical specialist.

A review of the resident's care plan indicated that the resident was to be offered a treatment in the afternoon for one hour. A review of the external specialist consultation notes addressed to the primary care physician at the home, indicated that the resident should have had a prescribed treatment for an indicated time period. Months later, the same specialist consultation notes indicated the same prescribed treatment five days each week. A few months after that, again the same specialist wrote on a prescription note indicating the same treatment should be provided daily.

RPN #106, PSW #107 and PSW #108 all stated that the resident was asked if they wanted the treatment, to which the resident would accept or refuse based on how they felt. They all stated that they felt it was the resident's right to accept or refuse the treatment. However, RPN #106 verified that acceptance or refusal of the prescribed treatment by the resident was not consistently documented in the resident's progress notes or elsewhere. A review of the resident's progress note indicated the same.

Sources: Resident's progress notes and care plan, interview with RPN #106 and others. [s. 30. (2)]

---

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the resident was dressed appropriately and in accordance with their preference.

A complaint was received by the MLTC related to the resident's seasonal clothing.

An interview with SDM #130 indicated that they discussed the resident's clothing preference with direct care staff to keep the resident comfortable seasonally.

The resident’s care plan indicated that the resident should have appropriate personal clothing items to wear seasonally. Progress notes indicated that the home’s clinical nurse lead requested more personal clothing items from the SDM to support the resident's needs.

The SDM did not provide enough personal items to support the resident's needs as stated by RPN #106 and PSW #108 during separate interviews; however the request for additional personal items to support the resident's clothing preference was not escalated to the home’s social worker (SW) or DOC to support the resident's preference and needs.

Sources: The resident’s progress notes, interviews with SDM, RPN #106, PSW #108 and others. [s. 40.]

---

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**3. A response shall be made to the person who made the complaint, indicating,**
**i. what the licensee has done to resolve the complaint, or**
**ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every written complaint made to the licensee or a staff concerning the care of a resident or operation of the home, a response was made to the person who made the complaint indicating what the licensee had done to resolve the complaint, or that the licensee believe the complaint to be unfounded and the reason for that belief.

A complaint was received by the MLTC related to resident's care concerns and the home’s non-response to written complaints.

A review of the written complaints sent to the MLTC and the investigation note forwarded by the home to the MLTC indicated that SDM #130 submitted multiple written complaints to team members in the home related to various care concerns.

One written complaint was sent by email to the home’s CEO. During a telephone interview with the MLTC Inspection Manager, the CEO indicated that the complaint was investigated, however they could not locate a written response to the complainant.

Sources: SDM complaint letters, the home's Complaint Policy #ADM-VI-18, interview with the home's CEO. [s. 101. (1) 3.]

---

**Issued on this 7th day of January, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | VERON ASH (535) |
| **Inspection No. / No de l'inspection :** | 2020_808535_0014 |
| **Log No. / No de registre :** | 002683-20, 003245-20, 016568-20 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jan 4, 2021 |
| **Licensee / Titulaire de permis :** | Broadview Foundation<br>3555 Danforth Avenue, Toronto, ON, M1L-1E3 |
| **LTC Home / Foyer de SLD :** | Chester Village<br>3555 Danforth Avenue, Toronto, ON, M1L-1E3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Cynthia Marinelli |

To Broadview Foundation, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

---

**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

-Educate RPN #121 and all registered practical nurses regarding the College of Nurses of Ontario's Practice Guidelines - specifically RN and RPN Practice and Intra-Professional Collaborative Practice among Nurses.

-Document the education, including the date, participants and the staff member who provided the education.

-Perform weekly audits related to RPN #121's work during each shift for a period of one month to ensure they collaborated with and consulted the RN, NM and physician as appropriate during the shift.

-Document the audits and all concerns arise with the RPN's practices.

-Develop and Implement a plan or protocol to ensure registered staff collaboration with members of the multiple disciplinary team such as RN, NM, PT, RD, MD, SW, SLP as appropriate and regardless of time of day, to support residents' health, safety or well-being.

-Document the plan or protocol for review when requested.

**Grounds / Motifs :**

1. The licensee has failed to ensure the resident was free from neglect by the licensee or staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.
A complaint was received by the Ministry of Long-Term Care (MLTC) regarding resident care concerns including neglect.

Over an identified period of two months, the resident experienced a significant change in their health status - deterioration in their alertness, reduced intake and unstable vital signs.

During one particular shift, RPN #121 documented and verified during the interview, that the resident's vital signs and overall health status had deteriorated, but that they did not notify the registered nurse in charge (RN), the nurse manager (NM) in the building, nor the on-call physician. Their reason was because they decided to to endorse the information to the next shift nurse so that the primary physician would be called. RPN #121 acknowledged that in retrospect, they should have notified the RN, NM and on-call physician about the resident's change in status.

The resident's vital signs and clinical status were reviewed with Physician #119 and Nurse Manager (NM) #112 during separate interviews, and both agreed that the resident's clinical status should have been communicated to the team for further assessment and possible treatment.

During that same period the resident's intake was reduced, however registered staff did not complete a referral to the home's registered dietitian (RD) for assessment and possible treatment; and the physician was not consulted tor review medication related to hydration status.

The speech language pathologist (SLP) completed a swallowing assessment which revealed swallowing difficulty related to their diagnosis. During that same period, staff continued to feed the resident with no further referral to the RD or SLP, although the resident's alertness was decreased.

The resident's progress notes and an interview with RPN #109 verified that the

resident was transferred to hospital two shifts later after a discussion with the RN and physician.

The Inspector discussed the hospital discharge summary with Physician #119, who acknowledged from the discharge summary that the resident had experienced complications related to their change in condition.

Sources: The resident's progress notes, E-MAR, MDS, Food and Fluid Records, SLP assessment, interviews with RPN #109 and #121, NM #112, DOC and Physician #119 and others. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There were patterns of inaction displayed by RPNs related to responding to the resident's change in condition. RPN #121 did not consult with the RN, NM or the on-call physician when the resident's health status deteriorated during the shift. Multiple RPNs documented that the resident's state of alertness had decreased, however staff continued to feed the resident with no referral to RD or SLP. The discharge summary indicated that the resident had experienced complications related to their change in condition. There was actual harm to the resident since they further deteriorated and passed away after transfer to hospital.

Scope: This non-compliance was isolated since the incident was related to one resident.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with other sections of the LTCHA and O. Reg 79/10. (535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 26, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

---

**Order # / No d'ordre :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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).

**Order / Ordre :**

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

- Develop and implement a protocol or plan to ensure PSWs #107, #108, #111, and #118 and all other PSWs adhere to residents' care plan interventions - specifically related to feeding, bathing and ambulating residents.

- Document the plan/protocol initiation date, process of implementation and the staff member who implemented the plan/protocol.

-Perform weekly audits for a period of one month, by selecting and reviewing two random residents' care plan, including residents #003 and #004, to ensure self-performance codes documented in the care plan related to feeding, bathing and ambulating residents matches the actual level of supervision provided to those residents as specified in the plan.

-Document the result of each audit and actions taken, as applicable. Audits should include the name of residents audited, staff involved, home unit, date and time, and the name of the staff who completed the audit.

**Grounds / Motifs :**

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

On an identified date, the resident was left unattended in the washroom by a PSW; and they slipped from the chair and fell to the floor. A review of the post

fall assessment document indicated that the resident sustained an injury as a result of the unwitnessed fall.

A review of the resident's plan of care indicated the resident required two-persons physical assistance for bathing. PSW #118 verified that they left the resident unsupervised.

Source : The resident's progress notes and written care plan, interview with PSW #118 and other. [s. 6. (7)] (535)

2. A review of the resident's care plan indicated that the resident was not to have a specific gender PSW provide personal care. During an interview, PSW #116 stated that they unknowingly assisted the resident with personal care which required two PSWs, up to and including the summer months last year. The PSW stated that they were asked to help with personal care by the primary opposite gendered PSW; however they were not aware that the resident was not to have a specific gender PSW provide personal care or they would not have entered their room.

Sources: The resident's care plan, interviews with PSW #116 and others. [s. 6. (7)] (535)

3. Clinical records indicated that the resident had a speech-language pathologist (SLP) assessment completed and their recommendation was for staff to provide cut up assistance for larger food items. A review of the progress notes indicated that the home's registered dietitian (RD) wrote an order for staff to cut the resident's food items in bite-size pieces during meals.

RPN #106, #111 and PSWs #107 and #108 stated in separate interviews that sometimes they would provide cut up assistance during meals if the resident was served hard foods on their such as chicken or meat during meals. However, they did not consistently cut up their food items, especially if the meal was a sandwich since that was soft and the resident was able to hold and eat the sandwich by themselves. The resident's intake records also indicated that sometimes the resident was provided with assistance and sometimes no assistance was provided during meals.

Sources: The resident's care plan, nutrition records and progress notes, SLP clinical consultation notes, interviews with PSWs #107 and #108 and others. [s. 6. (7)] (535)

4. The resident's SDM requested that all direct caregivers should perform a specified intervention when providing direct and indirect care to the resident at all times.

A review of the resident's care plan indicated that this specific intervention was not included in the written care plan, however a sign was posted in the resident's room by NM #122 and the information was to have been communicated to all direct care staff. PSW #108 revealed during an interview that they removed all the signs posted in the resident's room. PSW #107 and #108 acknowledged during separate interviews that they did not perform that intervention consistently since they were not aware that the intent of the sign posted in the room meant to always perform that specific intervention during all contact with the resident.

Sources: The resident's electronic and printed care plan, interview with PSW #107 and #108 and others. [s. 6. (7)]

An order was made by taking the following factors into account:

Severity: PSWs did not follow the plan of care as specified while providing care to residents. There was actual harm to one resident since the PSW left the resident unattended and they slipped out of the chair and fell on the floor causing an injury.

Scope: This non-compliance was widespread since there were three residents with findings related to care not being provided as specified in the plan of care.

Compliance History: One written notification (WN) and two voluntary plans of correction (VPCs) were issued to the home related to the same sections of the legislation in the past 36 months. (535)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Feb 26, 2021

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 4th day of January, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Veron Ash

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office