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

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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
Apr 16, 2021	2021_751649_0006	000387-21, 000489-21, 000490-21, 000621-21	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

JULIEANN HING (649)

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): March 25, 26, 30, 31, April 1, 6, 7, and 8, 2021.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Log #000387-21- related to plan of care, and
Log #000621-21- related to falls prevention and management.

The following Compliance Order (CO) follow-up intakes were completed during this CIS inspection:
Log #000498-21 - related to plan of care; and
Log #000490-21 - related to prevention of abuse and neglect.

PLEASE NOTE: A Written Notification (WN) and a Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (7) identified in a concurrent inspection #2021_751649_0007 (Log #024643-20 and #024670-20) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Nurse Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Aide, Housekeepers, and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted resident observations, reviewed residents' clinical records and staffing schedules.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)
2 VPC(s)
0 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_808535_0014	649
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2020_808535_0014	649

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report related to a resident who sustained an injury of unknown cause. The resident was transferred to hospital and diagnosed with an injury. The resident required two-person assistance with transferring, using a mechanical lift. Two PSWs confirmed that they had not followed the resident's plan of care when they transferred the resident by themselves using the mechanical lift. They both denied that any injury to the resident had occurred with them. They received disciplinary action from the home for failure to follow the resident's plan of care.

Sources: resident's health records, home's investigation notes, staffing schedules, interviews with PSWs, DOC, and other staff. [s. 6. (7)]

2. A complaint was received by the Ministry of Long-Term Care (MLTC) related to unexplained injuries sustained by a resident. The home submitted a CIS report related to the injuries the resident had sustained. The home conducted extensive staff interviews, but was unable to determine how the resident's injury had occurred. The resident required two-person assistance with transferring, using a mechanical lift. A PSW confirmed that they had not followed the resident's plan of care when they had provided care to the resident on their shift and had failed to report any injury to the nurse. The PSW received disciplinary action related to this incident. They denied that any injury had occurred when they had provided care to the resident by themselves.

Sources: resident's health records, home's investigation notes, interviews with the PSW, DOC, and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A CIS report was submitted to the MLTC regarding a resident, who sustained an injury unrelated to a fall. This report indicated that the resident was observed with altered skin integrity, and later diagnosed with an injury. The home conducted an investigation but was unable to determine how the resident had sustained the injury. A PSW told the inspector that they had taken the resident after bathing to the RPN and showed them that the resident's had altered skin integrity. This was witnessed by another PSW. The RPN confirmed being shown by the PSW of the resident’s altered skin integrity and recalls providing a treatment. There was no documentation of an assessment or provision of care provided by the RPN who told the inspector they became distracted with something else. This was brought to the DOC’s attention who told the inspector they expected documentation of an assessment.

Sources: resident’s health records, CIS report, home’s investigation notes, interviews with PSWs, RPN, and DOC. [s. 6. (9) 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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that provision of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to one resident in accordance with the directions for use specified by the prescriber.

The home submitted a CIS report related to a resident, who sustained an injury of unknown cause. The resident was transferred to hospital and diagnosed with an injury. The resident had an order for analgesic for pain management that was not administered when there was documentation of pain. An incident report completed by the RN indicated that the resident had pain post injury. The ADOC confirmed that no pain medication was administered to the resident when there was documentation of pain.

Sources: resident's health records, electronic-medication administration record (e-MAR), and interview with ADOC. [s. 131. (2)]

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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 19th day of April, 2021

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

Original report signed by the inspector.