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

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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 9, 2022	2022_891649_0001	000387-22	Proactive Compliance 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

JULIEANN HING (649), IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 11, 12, 13, 14, 18, 19, 20, 21, and off-site on January 17, 2022.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Acting Director of Care (A-DOC), Environment Services Manager (ESM), Food Service Manager (FSM), Activation Manager (AM), Registered Dietitian (RD), Registered Nurses (RNs), Physiotherapist (PT), Infection Prevention and Control (IPAC) Lead, Behaviour Support Outreach Team (BSOT) Lead, Registered Practical Nurses (RPNs), Customer Service Coordinator, Staff Schedule Coordinator, Personal Support Workers (PSWs), Dietary Aides (DAs), Housekeeping Staff, Screener, Members of the Residents' Council and Family Council, Residents and Family Members.

During the course of the inspection, the inspectors observed meal and snack service, medication administration, Infection Prevention and Control (IPAC) Practices, Residents' care areas, and reviewed residents' and home's records and pertinent home policies.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

4 WN(s)
4 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 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The resident was to receive a minced texture diet. Observations of the resident by inspector #646 showed the resident was provided a pureed texture entree at mealtime.

The Dietary Aide (DA) indicated they would follow the diet list which showed minced texture for the resident. The DA indicated the staff had been asking for pureed texture, and that the diet list needed to be updated.

The Personal Support Worker (PSW) who fed the resident indicated they were provided a pureed entrée by the dietary staff. The PSW indicated the resident had difficulty with the minced texture, and staff had been providing pureed texture for several months. The PSW indicated this had been communicated to the registered staff and they thought the care plan had been updated.

Registered staff members reported that they should send a referral to the Registered Dietitian (RD) when a resident was having difficulty with their diet texture. No referral was completed for the the RD to assess the resident's tolerance to minced texture.

The Acting-Director of Care (A-DOC) indicated the staff needed to communicate and collaborate so that residents would be referred and assessed to determine the appropriate diet texture, and this had not been done.

[Sources: Review of Diet List in the unit servery binder, Resident’s care plan, progress notes and nutritional assessments; Observation of meal service, observation of staff’s provision of meal to the resident; Interviews with PSWs, RD, A-DOC, and other staff.] [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care for the resident, so that the different aspects of care were integrated, consistent with and complemented each other.

The resident was to be provided two different continence products on day shift as per the unit's continence product list. The distribution list for the resident’s unit only included one continence product. The PSW distributed supplies weekly to all units based on the distribution list, which included only one of the continence products for the resident.

The PSW indicated they were aware that the incontinent list indicated to provide a specific continence product for the resident on day shift but, thought that the two continence products were the same.

The Registered Practical Nurse (RPN) indicated that the two continence products were the same size, but one was more absorbent. The RPN indicated that one of the continence products were not stocked on their unit.

The A-DOC indicated that the resident was to be provided a specific continence product on day shift. Registered staff had not informed them that they needed the continence product on the resident’s unit. The A-DOC indicated the continence list and distribution list should reflect the specific continence product to be stocked on the resident’s unit.

When staff did not collaborate, the resident was not provided their continence product

based on their assessed needs, and there was a risk of the resident not being clean, dry, and comfortable.

[Sources: Review of resident's care plan, unit's Incontinent List, Distribution list; Observation of resident, Unit continence product storage; Interviews with PSWs, RPN, A-DOC, and other staff.] [s. 6. (4) (b)]

3. The licensee has failed to ensure that one resident was reassessed and the plan of care reviewed when the care set out in the plan was no longer necessary.

The resident's diet list indicated they were to receive thickened fluids. The resident's care plan did not include information regarding the resident's fluid consistency.

Review of the resident's progress notes and assessments for the past quarter did not indicate the resident had difficulty with fluid consistency.

Observation of the resident showed the resident received regular fluids. The resident indicated they did not recall having received thickened beverages.

The PSW indicated the resident had regular fluids. Two DAs indicated the resident received regular fluids, and that the diet list needed to be updated.

The Food Service Manager (FSM) indicated the resident may have been trialed on thickened fluids earlier and the diet list was temporarily changed, but the diet list was not changed back.

There was a risk that the resident would not be provided with the correct fluid consistency when the diet list was not updated, and their written care plan did not include information regarding their fluid consistency.

[Sources: Review of the Diet List – Dated December 13, 2021, Resident's care plan, progress notes and nutritional assessments; Observations at mealtime; Interviews with Resident, PSW, DAs, RD and the FSM.] [s. 6. (10) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and 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, and
ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee shall ensure that written policies and protocols were developed the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2)

Specifically, staff did not comply with the home's Storage of narcotic and controlled medications policy #RCSM-F-55, last reviewed September 28, 2020, that directed staff to

make an entry and document administration at the time the medication was removed. The policy also stated that at every shift change a count should be done by two registered staff outgoing and incoming.

Observation of the resident's medication administration, revealed that the RPN had not signed the Narcotic and Controlled Drug Administration Record for the two controlled medications they had administered to the resident.

Later review of the Narcotic and Controlled Drug Administration Record, confirmed the inspector's observation that the RPN had not signed the Narcotic and Controlled Drug Administration Record during the above mentioned observation. While conducting this review the inspector discovered that another resident's medication was administered to the resident; both residents were prescribed the same medication.

The RPN acknowledged that they had not signed the Narcotic and Controlled Drug Administration Record for the resident at the time of administration of the two controlled medications. They also confirmed that they had accidentally taken a medication from another resident's narcotic card and given it to the resident. Both residents had the same medication dose.

Sources: Observation of medication administration, review of resident's electronic - Medication Administration Record (e-MAR), observation of residents' narcotic cards, and interview with RPN. [s. 8. (1) (b)]

2. As a result of the above non-compliance, the sample was expanded to include another home area.

During review of the Narcotic and Controlled Drug Administration Records on another home area, the RPN divulged that they had not been consistently counting the narcotics with the night registered staff. They acknowledged according to College of Nurses of Ontario (CNO) Standards that the narcotics must be counted by two registered staff.

This observation was brought to A-DOC's attention who advised that their expectation was for two nurses to count and sign Narcotic and Controlled Drug Administration Records together at each shift change.

Sources: Review of Narcotic and Controlled Drug Administration Records, interviews with RPN and A-DOC. [s. 8. (1) (b)]

3. Specifically, staff did not comply with MediSystem policies and procedures manual last updated August 2021 under the title of Destruction of discontinued/expired medications that indicated lids on the waste containers should be sealed once in use and medication inserted through the opening in the lid.

Observation of the waste container on the home area indicated that the lid of the waste container was unlocked and previously discarded medications were accessible.

The RPN demonstrated that they had access to previously discarded medications by opening the lid of the waste container. They explained that the lid of the waste container had to be left open in order to dispose of medications in larger boxes as they were not be able to fit through the opening in the lid.

This observation was brought to A-DOC's attention who acknowledged that the lids of the waste containers must be sealed once in use to avoid access to previously discarded medications.

Sources: Observation of waste container bin on the home area on January 17, 2022, review of MediSystem policies and procedures manual last updated August 2021, and interviews with RPN and A-DOC. [s. 8. (1) (b)]

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 plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident was bathed, at a minimum, twice a week by the method of their choice.

The resident's care plan indicated the resident was to be given a bath on one day and a shower on a second day each week.

The resident indicated they were usually bathed once per week and preferred a tub bath. They further indicated in the past few months, they had received bathing once a week or less, as the staff who bathed them was not always available.

The resident's bathing records for two months, documented only two baths were given to the resident each month. During the first half of a third month showed the resident had refused all bathing.

The PSW indicated that the spa team was not available on one of the resident's bath days, and the resident did not have a bath. The PSW also had not offered a shower or bed bath to the resident.

The Customer Service Coordinator indicated that due to staffing needs during outbreaks, the spa team PSWs were assigned to work as regular PSWs.

The PSW indicated that since the outbreak in the home, they were assigned other duties, and had not been able to provide the resident a tub bath on their bath day.

The A-DOC indicated the resident was not provided with bathing twice a week by the method of their choice. The A-DOC further indicated the PSWs should offer the resident a shower or bed bath if the resident was not able to be given a tub bath.

[Sources: Resident's care plan, Documentation Survey reports; Observation of the resident; Interviews with resident, PSWs, RPN, Customer Service Coordinator, A-DOC, and other staff.] [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: 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 disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The inspectors arrived on-site at the long-term care home on January 11, 2022, and were informed by the home's Chief Executive Officer (CEO) that the home was experiencing a Coronavirus (COVID-19) outbreak.

Inspector #649 requested a copy of the home's Critical Incident System (CIS) report for the reportable outbreak. It was at this time that the home became aware that they had not reported the outbreak as was required through the CIS report to the Director.

The home provided documentation that indicated a CIS was created on December 28, 2021, for the outbreak that was declared by Public Health on December 22, 2021. The CIS report was kept in a saved status by the home, until it was deleted by the system on January 9, 2022. As a result, of not changing the status of the CIS report from a saved to a submitted status resulted in it not being reported to the Director.

The A-DOC and CEO both acknowledged that the home had failed to report the outbreak as was required to the Director.

Sources: Documentation of deleted CIS #2970_000018_21, CIS #2970_000001-22, and interviews with A-DOC and CEO. [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, 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) of an outbreak 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 17th day of February, 2022

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

Original report signed by the inspector.