Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 24, 2023	
Inspection Number: 2023-1453-0001	
Inspection Type: Critical Incident System	
Licensee: Broadview Foundation	
Long Term Care Home and City: Chester Village, Toronto	
Lead Inspector Nira Khemraj (741716)	**Inspector Digital Signature**
Additional Inspector(s) Kim Lee (741072)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 6, 9, 10, 12 and 13, 2023.

The following intake(s) were inspected:
- Intake: #00002859- [CI: 2970-000013-21] Fall of resident resulting in injury.
- Intake: #00013525- [CI: 2970-000009-22] Medical emergency resulting in hospitalization.

The following intake(s) were completed:
- Intake: #00002856- [CI: 2970-000008-21] Fall resulting in injury and hospitalization.
- Intake: #00001902- [CI: 2970-000016-21] Fall resulting in injury and hospitalization.
- Intake: #00003247- [CI: 2970-000012-21] Fall resulting in injury and hospitalization.
- Intake: #00003600- [CI: 2970-000002-22] Fall resulting in injury and hospitalization.
- Intake: #00008908- [CI: 2970-000007-22] Fall resulting in injury and hospitalization.

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

Infection Prevention and Control
Medication Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that resident #002's plan of care was revised when the care set out in the plan of care was no longer necessary.

Rationale and Summary

Resident #002's plan of care indicated that the resident required various falls prevention devices.

Resident #002 was observed utilizing a mobility device with required falls prevention devices not present. Resident #002 also did not have required falls prevention devices present in their room.

Personal Support Worker (PSW) #102 acknowledged that resident #002 did not have the required falls prevention devices outlined in the plan of care in place. PSW #102 stated that the resident was not at risk for falls and that the falls prevention devices not observed to be in place were not required for resident #002. PSW #102 stated that resident #002's plan of care was not updated with the most current falls interventions.

Physiotherapist (PT) #110 stated that resident #002 was no longer at risk for falls and no longer required the falls prevention devices. PT #110 stated that it was the duty of nursing staff to update plans of care with respect to changes in fall interventions.

RPN #111 stated that care plans are usually updated by registered staff and acknowledged that the care plans were not always updated.

There was no impact to resident #002 because the resident was no longer at risk for falls. There was risk

that staff would not know that falls interventions had changed for resident #002.

Sources: Resident #002's care plan, observations on January 6, 2023, interview with staff.

[741072]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that Post-Fall Assessments were conducted when resident #002 fell.

Rationale and Summary

Resident #002 fell on two dates. Post-Fall Assessments were not completed including head-to-toe and fall risk assessments for these two falls.

The LTCH's policy stated that when a resident has fallen, registered nursing staff are to conduct a post-fall assessment that includes a head-to-toe assessment and fall risk assessment.

Registered Practical Nurse (RPN) #109, the Falls program lead and PT #110 stated that when a resident has fallen, registered nursing staff conduct a post-fall assessment.

Acting Director of Care (DOC) #105 stated that when a resident has fallen, a post-fall assessment is conducted.

There was no impact to resident #002's health status as a result of the post-fall assessments that were not conducted. Failing to conduct a post-fall assessment put the resident at risk for undetected fall-related injuries and could have hindered the LTCH's ability to manage future fall risks.

Sources: Post-Fall Assessments for resident #002, interview with staff, LTCH Fall Prevention & Management policy.

[741072]

WRITTEN NOTIFICATION: Policies to be Followed

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 8 (1) (b)

The licensee has failed to ensure that the LTCH's Head Injury Routine (HIR) was complied with when it was required after resident #002 sustained multiple falls.

O. Reg. 79/10, s. 48 (1) (1) requires every licensee of a long-term care home to ensure a falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the "Head Injury Routine" policy which was included in the licensee's Fall Prevention & Management Program.

Rationale and Summary

A HIR was initiated for resident #002 on various dates. The LTCH's HIR policy stated that residents on the HIR would be observed, assessed, and monitored, according to established guidelines in the policy. Multiple HIR assessment entries were not conducted at the required intervals specified in the LTCH's HIR policy or were not conducted at all.

RPN #109 stated that when a resident has fallen, assessments must be completed that may include a HIR. RPN #109 stated the HIR was to be completed in specific circumstances and there were specific time intervals to complete the assessment.

DOC #105 stated that when a resident has fallen, assessments must be completed that may include a HIR. When a HIR is initiated, it is expected to be completed according to the LTCH's policy. Staff would have been expected to follow the assessment intervals as written in the policy. An HIR is conducted to prevent delay in identifying significant changes in a resident's health status, post fall.

There was no impact to resident #002's health status as a result of the HIR assessments that had been conducted or not conducted. Failing to comply with the LTCH's HIR policy put the resident at risk for delayed identification of changes to the resident's health status following a fall.

Sources: Interviews with RPN #109 and acting DOC #105, LTCH's HIR procedure document.

[741072]

WRITTEN NOTIFICATION: Directives by Minister

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee of the long-term care home has failed to ensure that they carried out every operational or policy directive that applies to the long-term care home.

Rationale and Summary

As per the minster’s directive, residents are to be assessed at least once a day for signs and symptoms of COVID-19, including temperature checks. In review of resident #001 and #002’s clinical records, there was no documented assessment completed daily for COVID-19 or evidence of temperature checks. In interviews with RN #104 and RPN #111, it was confirmed that daily assessments for COVID-19 including temperature checks of residents were not being completed.

In an interview with IPAC lead #108, they confirmed that staff currently were documenting assessments for COVID-19 signs and symptoms including temperature checks only if the resident was exhibiting signs and symptoms of infection.

Due to the home not following the minister's directive there was a risk of harm to residents, staff and visitors related to the spread of infectious disease.

Sources: Review of resident #001 and #002’s clinical records, interviews with RN #104, RPN #111 and IPAC lead #108.
[741716]

WRITTEN NOTIFICATION: Compliance with Manufacturers' Instructions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 26

The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions as it relates to the Rapid Antigen Test (RAT) kits.

Rationale and Summary

Observations of the home's Infection Prevention and Control (IPAC) practices related to Rapid Antigen Testing (RAT) identified that two visitors did not follow the manufacturer's instructions of the RAT testing device. The Inspector observed visitors administering the RAT on themselves and proceeded to the waiting area for the test to process. The visitors were both observed proceeding to their visit in less than the required processing time. IPAC lead #108 acknowledged that visitors who perform self-testing are to follow the manufacturer's instructions, which specifies that results should be read after the required processing time.

Due to the home not following the RAT device instructions, there was a risk of harm to residents, staff and visitors related to the spread of infectious disease.

Sources: Standard Q COVID-19 Ag nasal test, observations of visitor RAT testing and interview with IPAC lead #108.
[741716]

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) (1)

The licensee has failed to ensure that a falls interdisciplinary program was implemented in the home to reduce the risk of injury.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the LTCH's HIR policy included in the licensee's Falls Prevention and Management program was complied with when it was required after resident #001 sustained a fall.

Rationale and Summary

Resident #001 was found on the floor by PSW #114 who informed RPN #116 of the fall. RPN #116 assessed the resident and determined the resident needed to be sent out to hospital for further treatment due to a medical emergency. RPN #116 confirmed that they did not initiate the Head Injury Routine (HIR) due to the resident being sent out to hospital. RPN #106 and #115 confirmed they did not initiate the HIR upon the resident's return to the home.

As per the home's policy for Head injury routine, staff are to ensure the resident will be closely observed and assessed including the monitoring of vital signs according to established guidelines following a head

injury or suspected head injury.

Failure of the home to complete the HIR may have contributed to an increased risk to the resident's health.

Sources: Review of resident #001's clinical records, LTCH's HIR policy and interviews with RPN #106, RPN #115, RPN #116 and PSW #114.
[741716]

COMPLIANCE ORDER CO #001 Administration of Drugs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 140 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:

The licensee shall:

1. Re-train RPN #106 on safe administration of medication and monitoring practices.
2. Document the content of the education provided, including the date and the staff member who provided the education.

Grounds

The licensee has failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

Rationale and Summary

Resident #001 was re-admitted from hospital in stable condition.

Resident was prescribed medication which was to be administered at a scheduled time with corresponding monitoring.

In an interview with RPN #106, they confirmed they gave the medication at later time because of a delay in the readmission process. RPN #106 stated they monitored prior to administering the medication, but there was no documentation. Resident should have been monitored and documented in the Electronic medication administration record (eMAR) prior to and following the medication administration as per

the monitoring schedule. By not adhering to the prescribed time, this resulted in resident experiencing a medical emergency.

Failure of the home to follow the prescriber's orders led to increased health risk to the resident.

Sources: Review of resident #001 clinical records, CIS #2970-000009-22 and interview with RPN #106.

[741716]

This order must be complied with by February 6, 2023

COMPLIANCE ORDER CO #002 Documentation

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:

The licensee shall:

1. Train RPN#106 on how to remove a hold on a resident in the eMAR and re-train on documentation practices associated with medication administration in eMAR.
2. Document the content of the education provided, including the date and the staff member who provided the education.

Grounds

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for resident #001.

Rationale and Summary

Resident #001 was re-admitted from hospital in stable condition. RN #104 completed the readmission for resident upon return. In an interview with RN #104, they stated they were completing readmissions for two residents. Once RN #104 completed the readmission for the resident they informed RPN #106 so they could proceed with administering the medications. RN #104 was unable to provide time of completion of the readmission and when they informed RPN #106 to administer the medications.

In the eMAR there was no sign off for the medication administration or monitoring that was taken by

RPN #106. In an interview with RPN #106, they confirmed they monitored prior to administering the medication but did not sign off in the eMAR as they did not know how take the resident off hold in the eMAR.

Failure of the home to document the provision of care set out in the plan of care may have led to errors in medication administration and put the resident at increased health risk.

Sources: Review of resident #001 clinical records, interviews with RN#104 and RPN #106.
[741716]

This order must be complied with by February 6, 2023

COMPLIANCE ORDER CO #003 Plan of Care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:

The licensee shall:

1. Re-train RPN #106 on providing care as outlined in the plan of care, specifically related to the interventions in place to manage resident's medical diagnosis.
2. Document the content of the education provided, including the date and the staff member who provided the education.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary

Resident #001 was re-admitted from hospital in stable condition. RN #104 completed the readmission for resident upon return. In an interview with RN #104, they stated they were completing readmissions for two residents. Once RN #104 completed the readmission for the resident they informed RPN #106 so they could proceed with administering the medications. RN #104 was unable to provide time of completion of the readmission and when they informed RPN #106 to administer the medications.

Prior to administering the medication at a later time, RPN #106 documented the resident ate well and that they performed the required monitoring. As per resident's plan of care, staff must monitor resident intake.

PSW #103 confirmed they documented the intake for the resident and that they were not asked about the resident's intake by RPN #106. RPN #106 confirmed they had not verified the intake by speaking with PSW #103 or reviewing the intake documentation made by PSW #103.

Failure to monitor resident intake contributed to increased health risk to the resident.

Sources: Review of resident #001 clinical records, interviews with RN #104, RPN #106 and PSW #103. [741716]

This order must be complied with by February 6, 2023

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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