Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 7, 2024
Inspection Number: 2024-1453-0001
Inspection Type: Critical Incident
Licensee: Broadview Foundation
Long Term Care Home and City: Chester Village, Toronto

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2024.03.11 15:49:43 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20-22, 26, 27, 29, 2024 and March 1, 2024

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00101578 [CI: 2970-000018-23] - related to the fall of a resident
- Intake: #00105453 [CI: 2970-000001-24] - related to a disease outbreak
- Intake: #00106073 [CI: 2970-000002-24] - related to an injury of unknown cause

The following intake was completed in this CI inspection:

- Intake: #00100764 [CI: 2970-000016-23] - related to a disease outbreak

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

Resident Care and Support Services
Infection Prevention and Control
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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident related to their protective device after an injury.

Rationale and Summary
A resident had a device after an injury. Documentation indicated that the resident's device was applied incorrectly on more than one occassion. Furthermore, documentation indicated that the resident continued to have this device applied when it had already been discontinued. The resident's written plan of care did not contain information regarding the planned care to apply or remove this device.

A Personal Support Worker (PSW) confirmed that they received only verbal directions regarding the care of the resident's device. The Assistant Director of Care (ADOC) acknowledged that the planned care for the resident's device was not in their written plan of care, and therefore staff who provided direct care to the resident were not made aware of the care specifications and discontinuation of the device.

Failure to ensure that the planned care for the resident's device was included in the written plan of care led to lack of staff awareness of the care specifications and discontinuation of the device.

Sources: Resident's clinical records; Interviews with a PSW, ADOC and other staff.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

The licensee has failed to ensure that Additional Precautions were followed by staff

in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023. Specifically, staff did not select the appropriate Personal Protective Equipment (PPE) as required by Additional Requirement 9.1 (d) under the IPAC standard.

Rationale and Summary

i) A PSW was observed exiting a resident's room on a resident home area on additional precautions with gloves, gown, and a mask donned. The signage posted on the door of the resident's room indicated that they were on a specific type of additional precautions and staff were required to don eye protection, gloves, gown and a mask to enter the room.

The PSW indicated that eye protection was not necessary to enter the resident's room and therefore had only worn gloves, gown and a mask. The IPAC Lead confirmed that staff are expected to wear eye protection in addition to the gloves, gown and a mask for residents on this type of additional precautions.

Failure to ensure that eye protection is worn when entering a resident's room on this type of additional precautions can increase the risk for infection transmission.

Sources: Observations of a resident home area; precautions signage; interviews with a PSW and other staff.

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The licensee has failed to ensure that the hand hygiene program for residents was followed by staff in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), revised

September 2023. Specifically, residents were not assisted to perform hand hygiene before meals as required by Additional Requirement 10.2 (c) under the IPAC standard.

Rationale and Summary

ii) Staff on a resident home area assisted residents to their designated seats in the dining room for a meal service. Staff that were present in the dining room were observed not assisting several residents with performing hand hygiene prior to the meal service.

A Registered Practical Nurse (RPN) confirmed that residents were not assisted with hand hygiene when they were seated in the dining room. The IPAC Lead confirmed that staff are expected to offer or assist residents with hand hygiene before being served their drinks.

Failure to ensure that the residents are assisted to perform hand hygiene before meals can increase their risk of infection transmission.

Sources: Observations of a resident home area; interviews with the IPAC Lead and other staff.

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