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

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Original Public Report

Report Issue Date: September 25, 2024
Inspection Number: 2024-1453-0003
Inspection Type: Critical Incident
Licensee: Broadview Foundation
Long Term Care Home and City: Chester Village, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 23, 24, 2024

The following intake was inspected:

- Intake: #00126157 - Critical Incident Systems (CIS) report #2970-000015-24 related to a disease outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms were recorded on a shift.

Rationale and Summary
A resident was exhibiting symptoms of an infection. A review of the documentation indicated that the resident's assessments and/or symptoms were not documented on the progress notes or assessments section on PointClickCare (PCC) for a specific shift. The Infection Prevention and Control (IPAC) Lead stated that the home's process for monitoring residents who exhibit active symptoms includes documentation of the resident's vital signs on PCC either on the progress notes and/or on the assessments section of the resident's profile. The IPAC Lead confirmed that this process was not followed through for the noted shift.

Failure to document a resident's symptoms and assessments on each shift may lead to a delay in required treatments.

Sources: Review of a resident's progress notes and assessments on PCC; Home's line list of residents affected by the outbreak; Interview with the IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that a Personal Support Worker (PSW) wore appropriate personal protective equipment (PPE) when they interacted with a resident diagnosed with a respiratory infection as part of the directive issued by the Chief Medical Officer of Health (CMOH).

Rationale and Summary

A resident was diagnosed with a respiratory infection and was under precautions. A PSW was seen entering the resident's room without donning a N95 mask while they interacted with the resident. The PSW stated that because they were not providing direct care to the resident, that it would be appropriate to wear a surgical mask when they interacted with the resident. The IPAC Lead stated that staff were to don a N95 mask when entering and interacting with a resident diagnosed with the respiratory infection and confirmed that the PSW did not don the appropriate PPE.

Failure to ensure that the appropriate PPE was worn when interacting with a symptomatic resident may result in further spread of the disease.

Sources: Observation with a PSW; Interview with the PSW and the IPAC Lead.