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: July 17, 2024.
Inspection Number: 2024-1453-0002
Inspection Type: Complaint Critical Incident
Licensee: Broadview Foundation
Long Term Care Home and City: Chester Village, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2-5, and 8-10, 2024.

The following intake(s) were inspected:

- Intakes #00110140-Critical Incident (CI) 2970-000004-24 and #00112667-CI #2970-000010-24 were related to fall prevention and management.
- Intake #00114744-CI #2970-000011-24 was related to infection prevention and control.
- Complaint Intakes #00112129, #00112828, #00112880, #00116439 and, #00115767 were related to safe and secure, resident care and services, skin and wound management and, infection prevention and control.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.
NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure a bottle of a specified substance was kept inaccessible to residents at all times.

Rationale and Summary

During an observation a bottle containing a specific substance was noted on a cart outside a resident's room. The area was unattended.
RPN confirmed that the bottle containing the specified substance should have been kept inaccessible to residents for their safety and, immediately removed the bottle.

Failure to properly store and keep the bottle with the specified substance inaccessible to residents' placed them at risk of harm.

Sources: Observations, interview with RPN.

[000825]

Date Remedy Implemented: July 10, 2024

WRITTEN NOTIFICATION: FLTCA 2021 s. 6 (4) (b) Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

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,

(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.

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

Rationale and Summary

The resident's care plan stated that their assistive device must be locked by the bed when they are in bed. During observations, it was noted that the resident's assistive device was in the washroom. PSW reported the resident requested this change and that they reported this request to the RPN. RPN stated that it was not reported to them by anyone that the resident's assistive device would be kept in the washroom or by their bed.

Physiotherapist reported the assistive devices should be by the bed but they failed

to communicate this to the direct care staff.

Failure of staff to collaborate in the development and implementation of the resident's plan of care resulted in the inconsistent delivery of the resident's care and placed the resident at an increased risk for falls.

Sources: Resident's care plan, observations, interviews with PSW and other relevant staff.
[000825]

WRITTEN NOTIFICATION: FLTCA 2021 s. 6 (7) Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident related to the resident's falls interventions.

Rationale and Summary

The resident's care plan stated that their assistive device must be locked by their bed when the resident is in bed. During an observation, it was noted that the resident's assistive device was in the washroom.

Falls Lead confirmed that the assistive device should be kept by the resident's bed.

Failure to leave the assistive device beside the resident's bed when they are in bed, as specified by the care plan, placed the resident at an increased risk for falls.

Sources: Observations, resident's care plan, interviews with PSW and other relevant staff.
[000825]

WRITTEN NOTIFICATION: O. Reg. 246/22, s. 54 (1) Falls Prevention and Management pursuant to O. Reg 246/22 11 (1) b Policies, etc., to be followed, and records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their strategies to reduce or mitigate falls specifically related to their falling star program.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there are strategies to reduce or mitigate falls and that they are complied with. Specifically, staff did not comply with the Fall Prevention and Management Program Policy.

Rationale and Summary

The resident had a fall whereby they sustained injuries. As per the home's policy, any resident who has a fall resulting in a serious injury should have a falling star logo placed on their door. Physiotherapist and Falls Lead both confirmed that the resident was not on the falling star program, and as per policy, the resident should be on the program.

Failure to implement the falling star logo in the resident's plan of care decreased the home's ability to reduce or mitigate falls for the resident.

Sources: Observations, Fall Prevention and Management Program Policy, interviews with Physiotherapist and other relevant staff.
[000825]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
The Licensee failed to ensure that when the resident had a skin injury, they received a skin assessment by an authorized person, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rational and Summary

On a specified date, the resident sustained a injury.

Upon review of the resident's clinical records it was identified that a specific assessment was not completed. Registered Practical Nurse (RPN) acknowledged they did not complete the specified assessment.

Staff failed to complete a specific assessment when they identified the resident sustained an injury, which increased the risk for delayed interventions and management of the injury.

Sources: Interview with RPN, resident's clinical records.
[000759]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 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.

(i) Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) and (d) stated that the licensee shall ensure that Routine Practices and Additional Precautions

were followed in the IPAC program. At minimum Additional Precautions shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact); and the proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rational and Summary

A PSW was observed pumping hand sanitizer onto two residents hands and left. The residents were confused on how to perform hand hygiene with the sanitizer and it was left in the middle of their palms.

The PSW acknowledged that both residents needed assistance with hand hygiene, but they did not assist the residents in rubbing the hand sanitizer for 15 seconds through the residents hands.

The House Keeper (HK) was observed cleaning a unit which was on outbreak, every time they removed their gloves and put on new ones, they did not sanitize their hands. When the HK threw the garbage out from their caddie they did not remove their soiled gloves and, continued to put a clean plastic bag into their caddie with the same soiled gloves.

The HK acknowledged they did not sanitize their hands when they removed their gloves or put on new ones and they should have. As well as, they should have removed their gloves after throwing away the garbage, and sanitized their hands prior to moving on to a clean task.

Staff's failure to follow proper hand hygiene and PPE practices as specified in the

IPAC Standard, put the management of the infection prevention and control program at risk.

Sources: Interviews with PSW and other relevant staff, observations on a specified date.

(ii) Specifically, IPAC Standard for Long-Term Care Homes, s. 10.4 (d) (i) stated homes must complete monthly audits of adherence to the four moments of hand hygiene by staff.

Rationale and Summary

Upon review of the home's hand hygiene audits it was identified that there were no hand hygiene audits completed for a specified month.

The Director of Care (DOC) acknowledged that there were no hand hygiene audits completed for the specified month.

The home's failure to comply with monthly hand hygiene audits put the management of the infection prevention and control program at risk.

Sources: Interview with DOC and, home's hand hygiene audits.
[000759]