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

Public Report

Report Issue Date: April 15, 2025

Inspection Number: 2025-1453-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Broadview Foundation

Long Term Care Home and City: Chester Village, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 1- 4, 7 - 11, 14 - 15, 2025.

The following Compliance Order Follow Up inspections were completed:
-Intake: #00136159 - Follow-up #: 1 - O. Reg. 246/22 - s. 272
-Intake: #00139736 - Follow-up #: 1 - O. Reg. 246/22 - s. 40

The following Critical Incident (CI) intakes were inspected:
-Intake: #00137961 - CI #2970-000002-25 - was related to injury of resident not related to a fall.
-Intake: #00138510 - CI #2970-000004-25 - was related to a disease outbreak.
-Intake: #00138798 - CI #2970-000005-25 - was related to improper care of a resident.
-Intake: #00141346 - CI #2970-000007-25 - was related to the fall of a resident resulting in injury.

The following intakes were completed:
-Intake: #00137862 - CI #2970-000001-25; #00143410 - CI #/2970-000009-25 - related to resident fall incidents resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1453-0004 related to O. Reg. 246/22, s. 272
Order #001 from Inspection #2025-1453-0001 related to O. Reg. 246/22, s. 40

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (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 a resident's care, collaborated with each other in the implementation of

the plan of care so that the different aspects of care were integrated, and were consistent with and complemented each other.

On a specific date, the physician ordered a diagnostic test to assess a resident due to a change in their condition. The nurses failed to follow-up with the order which led to a delay in completing the test. Following the diagnostic test, the resident was diagnosed with a health condition that required further intervention.

Sources: Resident's clinical records; interviews with the home's staff.

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to follow their pain management program policy when a Registered Nurse (RN) did not complete a pain assessment on a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that the written policy developed for the pain management program was complied with when a resident exhibited pain.

Specifically, the home's pain management program policy stated that registered nursing staff were to collaborate with the resident to conduct the pain assessment utilizing a clinically appropriate instrument when they express pain concerns.

Sources: Resident's clinical records; interview with the home's staff; and Pain management program policy.

WRITTEN NOTIFICATION: Infection Prevention and Control Program - Symptom Monitoring

NC #003 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 has failed to ensure that a resident's symptoms were recorded on each shift when it was indicated. The resident's assessments and/or symptoms were not documented in the progress notes section on Point Click Care (PCC) for six shifts during the time that it was indicated.

Sources: Resident's clinical records; line List for Outbreak in CI 2970-000004-25; and interview with the home's staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Provide education to a specified Personal Support Worker (PSW) on the plan of care related to falls prevention intervention for a specified resident.
2.Provide education to a specified PSW on the licensee's policy and expectations for the implementation of resident care plans.
3.Maintain a record of the education from steps 1-2, including the content of the education, the date, the staff member who received the education, and the staff member(s) who provided the education.
4.Conduct audits, at minimum twice weekly on day shift for a two week period, on a specified resident's falls prevention interventions to ensure the interventions are in place as per their care plan.
5.Maintain a record of the audit from step 4, including the date, who conducted the audit, the name of the staff being audited, the results of each audit and actions taken in response to the audit findings.
6.Create and implement an action plan to ensure that agency nurses are orientated to the home's policy and expectations for developing, updating, and implementing residents care plans, including a process of identifying high risk residents to the agency nurses and identify staff roles and responsibilities when orientating new agency nurses to the home.
7.Maintain a record of the action plan, process for identifying high risk residents to agency nurses, and staff roles and responsibilities when orientating new agency nurses.
8.Keep in-service records for every new agency nurse receiving orientation moving forward on identifying high risk residents and the home's policy and expectations for developing, updating, and implementing residents care plans.

Grounds

i.On a specific date, an Agency Registered Practical Nurse (RPN) administered an intervention that contradicted the directions in the plan of care. As a result, the

resident exhibited a negative reaction, and required immediate intervention and treatment.

Sources: Resident's clinical records and interview with the Agency RPN.

ii.The licensee has failed to ensure that the care set out in the plan of care related to a resident's fall prevention interventions, was provided to the resident as specified in the plan.

A resident's care plan stated they required specific fall prevention interventions. However, an observation revealed these interventions were not in place. A PSW confirmed the care planned interventions were not in place. The Physiotherapist acknowledged the absence of these interventions increased the risk of resident falling.

Failure to ensure that resident #004's plan of care was appropriately implemented placed the resident at risk of falling and sustaining an injury.

Sources: Observations; resident's clinical records; and interviews with the home's staff.

This order must be complied with by June 13, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Provide education to two specified PSW's on the best practices and expectations for Hand Hygiene (HH) and Personal Protective Equipment (PPE) use.
2.Provide education to all staff on a specified unit on the home's procedure for maintaining PPE supplies for rooms on additional precautions.
3.Maintain a record of the education from steps 1-2, including the content of the education, the date, the staff members who received the education, and the staff member(s) who provided the education.
4.Conduct audits, at minimum twice weekly for a two week period, on two specified PSW''s HH and PPE practices.
5.Conduct audits, at minimum four times per week for a two week period on day and evening shift on a specified unit of PPE supplies for rooms on additional precautions.
6.Maintain a record of the audits from steps 4-5, including the date, who conducted the audit, the name of the staff being audited, the results of each audit and actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

i.Specifically, Additional Requirement 9.1 (f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023) states, "at minimum, additional precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal".

A PSW was observed about to enter a resident's room with an additional precautions signage on the door that indicated droplet contact precautions (DCP), specifically requiring isolation gowns, face shield/eye protection, mask and gloves before entering the room. The PSW missed the first step of performing HH before they donned the isolation gown, and they did not wear a face shield/eye protection before entering the room.

Additionally, a PSW was observed exiting a resident's room with the DCP signage on the door. The PSW missed the HH step when doffing their PPE; specifically after removing their mask, and before applying a new mask from the PPE supply caddy.

Failure to follow proper donning and doffing sequences for residents on additional precautions increased the risk for spread of infection.

Sources: Observations; Personal Protective Equipment Policy; and interviews with the home's staff.

ii.Specifically, section 6.2 states "the licensee shall make PPE available and accessible to essential visitors, appropriate to their purpose of visitation and level of risk in accordance with evidence-based practices."

A resident was placed on DCP and PPE supplies were made available on a yellow PPE caddy hanging on their room and a cart in the hallway. Shields were not available on the caddy or the cart, therefore an external service provider entered the resident's room without donning a shield.

A RPN acknowledged that shields should have been available for the resident on DCP and that there were no shields in the caddy or the cart.

Failure to ensure that PPE supplies were available resulted in a visitor entering a room on additional precautions without a shield and placed them at risk of

acquiring and spreading infection.

Sources: Observations; Personal Protective Equipment Policy; and interviews with the home's staff.

iii.Specifically, section 10.1 “the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). ABHR shall be easily accessible at both point-of care and in other common and resident areas, and any staff providing direct resident care must have immediate access to ABHR that contains 70-90% alcohol concentration”.

When leaving a room on additional precautions, a PSW used a disinfectant wipe that contained Hydrogen Peroxide 0.5% to clean their hands while doffing their PPE, not an alcohol-based hand rub. They acknowledged that they did not use the appropriate product when performing HH and the subsequent risk for spread of infection.

Failure to perform hand hygiene with an alcohol based hand rub when leaving a room on additional precautions increased the risk of infection transmission.

Sources: Observations; Hand Hygiene Policy; and interviews with the home's staff.

This order must be complied with by May 29, 2025

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.