Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2019	2019_644507_0003	001769-17, 019907-17, 021400-17, 002321-18, 002378-18, 011011-18, 001144-19	Complaint

Licensee/Titulaire de permis

Broadview Foundation
3555 Danforth Avenue TORONTO ON M1L 1E3

Long-Term Care Home/Foyer de soins de longue durée

Chester Village
3555 Danforth Avenue TORONTO ON M1L 1E3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

STELLA NG (507), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 30, 31, February 1, 4, 5, 6 (off-site), 7, 8, 11, 12 (off-site), 13, 14 and 15, 2019.

The following complaints were inspected concurrently with this inspection:
#001769-17 and #002378-18 (CIS #2970-000002-18) related to plan of care,
#019907-17 related to oral care and complaint investigation,
#021400-17 related to alleged staff to resident abuse and missing property,
#002321-18 related to plan of care and pain management,
#011011-18 related to plan of care, responsive behaviours, sufficient staffing and safe and secure home, and
#001144-19 related to falls prevention and safe and secure home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinator (RC), Activation Assistant (AA), Physiotherapist (PT), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, an identified critical incident system (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC). Two days later a complaint was submitted to the MOHLTC by resident #006's substitute decision makers (SDM). Both the CIS report and complaint were related to an incident that had occurred five days prior to the submission of the CIS, where resident #006 sustained an injury.

A) A review of the CIS report indicated that on the identified date, while the assigned staff member was providing care to resident #006 they heard a sound from the resident's body. The staff member called staff #109 to come and assess. Staff #109 then called staff #116 for further assessment. As a result of staff #116's assessment resident #006 was sent to hospital. The next day, resident #006 returned to the home with a diagnosis of an identified injury.

A review of resident #006's plan of care indicated they required total assistance with activities of daily living (ADL). The focus related to problematic behaviour indicated that if they had responsive behaviours, staff were to allow for flexibility in ADL routine, document the situation, inform the resident of care to be provided and if responsive behaviours persisted, to leave and re-approach in 15 minutes.

During an interview, staff #109 stated that upon entering resident #006's room, the resident was observed sitting upright in their chair. Staff #109 further stated that the assigned staff member had indicated resident #006 was having responsive behaviours when they were trying to provide care when they heard a sound. The assigned staff member became nervous and called for the staff.

During an interview, staff #116 stated that if resident #006 was having responsive behaviours the staff member should have stopped, left the room and re-approached as outlined in their plan of care.

The assigned staff member was no longer working in the home therefore, an interview was not conducted.

During an interview, staff #115 stated that the home's investigation had concluded there had been no abusive or malicious intent from the assigned staff member, that resident #006 had responsive behaviours, therefore staff #115 reluctantly acknowledged that the assigned staff member had not provided care as specified in the plan of care by stopping, leaving the room and re-approaching resident #006.

B) As a result of the CIS report and complaint the inspector conducted observations on three identified dates. Observations conducted on one of the three identified dates indicated two staff were present when providing care. After care was completed staff #112 took an identified type of sling (type A) from resident #006's closet and proceeded to put in place, however when staff #112 went to hook up the sling to the mechanical lift they realized the sling was incorrect and proceeded to locate another type of sling (type B) that was used for the transfer. Staff #112 stated that they used the type A sling before and did not know why it was still in resident #006's room.

A review of resident #006's current care plan indicated under the transferring focus that they required a two person total physical assistance with the mechanical transfer sling lift for all transfers.

A review of Arjo-Huntleigh manufacturer's recommendations indicated the type A sling had been specifically designed for toileting and hygiene functions as well the client must have adequate trunk control to be transferred using this type of sling.

During an interview, staff #120 stated that type A sling was not appropriate for

transferring resident #006. Staff #120 further stated the term, mechanical transfer sling lift, was used in the home and referred to a type B sling that should be used for all transfers with resident #006.

During a conversation, staff #113 acknowledged they had been using the type A sling and not the type B sling with resident #006 when transferring related to ease of use.

During an interview, staff #123 acknowledged that care was not being provided to resident #006 as specified in their plan of care. [s. 6. (7)]

2. C) On an identified date, the MOHLTC received a complaint in regard to resident #001's plan of care in relation to resident #001's fall which occurred three weeks prior.

In an interview, resident #001's SDM stated that on an identified date, resident #001 was found by a visitor lying on the floor with an identified injury. Resident #001 was not supported by a mobility device or staff when the fall occurred.

Review of resident #001's RAI-MDS completed approximately three months prior to the fall incident indicated resident #001 required extensive assistance from one-person physical assist for walking in corridor and locomotion on unit.

Review of resident #001's written plan of care completed approximately three months prior to the fall incident stated that the resident required one person to assist with ambulation related to impaired coordination.

Review of the progress notes for resident #001 stated that on the identified date at an identified time, resident #001 was found on the floor by a visitor. The visitor walked pass resident #001 in the hallway. The visitor heard a bang, when they turned they saw resident #001 lying on the floor. Resident #001's mobility device was at the nursing station at the time of the fall. Upon assessment, identified injuries were observed on resident #001. This was confirmed by an interview with staff #119.

In interviews, staff #105 and #119 stated resident #001 required staff's reminder to use the mobility device, and the resident was able to ambulate independently with the mobility device on the unit with supervision. Staff #119 further stated that on the above mentioned identified date, at the above mentioned identified time, resident #001 fell while walking in the hallway, and resident #001's mobility device was at the nursing station at the time. Staff #119 confirmed that resident #001 was not supervised by staff at the time

of the above mentioned fall.

D) On an identified date, the MOHLTC received a complaint in regard to the safety of the home which caused resident #001 to fall.

In an interview, resident #001's SDM told the inspector that on an identified date a resident's responsive behaviours caused injury to resident #001.

Review of the progress notes of resident #003 stated that on an identified date, at an identified time, resident #003 was exhibiting responsive behaviours towards staff and co-residents. Three staff members attended resident #003 and attempted to de-escalate the responsive behaviours. After the intervention, resident #003 was placed in the chair in the common area of the unit. Staff #106 stayed with resident #003 and adjusted the resident's chair. This was confirmed by interviews with staff #101 and #106.

Review of the video footage for the above mentioned date for the identified unit indicated that at an identified time, staff #106 was seen talking to resident #003. Resident #001 walking independently with a mobility device came into view. Approximately 50 seconds later, resident #001 was seen walking beside resident #003's right side. Resident #003 exhibited responsive behaviour towards resident #001. Staff #106 was standing at the left side of resident #003 at the time, and tried to defuse the situation. Five seconds later, staff #118 was seen assisting staff #106. This was confirmed during interviews with staff #106 and #118.

In an interview, staff #101 stated that upon assessment, resident #001 sustained an altered skin integrity, Staff #101 also stated resident #001 required supervision for ambulation on the unit.

In an interview, staff #106 stated staff were focused in attending to resident #003 after the intervention, and did not see resident #001 was walking in close vicinity.

In an interview, staff #101 stated resident #001 was not being supervised when the resident was walking on the unit at the time of the above mentioned incident. [s. 6. (7)]

3. The Licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On an identified date, the MOHLTC received a complaint in regard to the safety of the home which caused resident #001 to fall.

In an interview, resident #001's SDM stated that on an identified date at an identified time, resident #001 and the SDM were walking towards an identified unit. Resident #001 was ahead of the SDM. When resident #001 was at the door, the unit door was opened from inside by a visitor. The door hit resident #001's walker, and resident #001 fell.

Review of the most recent written plan of care for resident #001 completed approximately two months prior indicated the resident required two persons to assist with ambulation.

During the course of the inspection, the inspector observed resident #001 ambulated independently with a mobility device on the unit.

In interviews, staff #101, #104 and #105 stated resident #001 was able to ambulate independently with a mobility device with supervision on the unit. In interviews, staff #101 and #104 stated that resident #001 required the assistance for ambulation upon return from the hospital one week after the above mentioned fall. Both staff stated resident #001's mobility has improved since then. Staff #104 stated resident #001's written plan of care should be updated when the resident's mobility improved and did not require the assistance of two persons for ambulation. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the care set out in the plan of care is provided to the resident as specified in the plan, and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The Licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's responsive behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

On an identified date, the MOHLTC received a complaint in regard to an incident involving resident #001 and another resident which occurred the day before.

In an interview, resident #001's SDM stated that on the identified date, resident #001 walked into another resident's room. When resident #001 turned around to walk out of the room, the resident in the room exhibited responsive behaviours towards resident #001.

Review of residents #001 and #002's progress notes stated that on the above mentioned identified date, at an identified time, staff #101 heard a loud noise from an identified wing. When staff #101 arrived at resident #002's room, staff #101 found resident #001 in the room. Resident #002 was exhibiting responsive behaviours towards resident #001. Staff #101 guided resident #001 out of resident #002's room. Upon assessment, an altered skin integrity was noted. This was confirmed by an interview with staff #101.

In interviews, staff #101, #105 and #119 stated that resident #001 ambulated with a mobility device on the unit.

Review of #002's progress notes for a period of six months prior to the above mentioned incident indicated that on an identified date approximately two months prior to the incident, a resident approached resident #002, resident #002 exhibited same responsive behaviours towards the other resident as towards resident #001 on the above mentioned identified date.

Review of resident #002's RAI-MDS completed approximately two weeks prior stated that the resident exhibited the previous described responsive behaviours one to three days in the previous seven days, and the behaviour was not easily altered.

In interviews, staff #101, #102 and #119 stated that resident #002 always exhibited responsive behaviours in the afternoon, and did not like other residents approaching them. When resident #002 started exhibiting responsive behaviour, staff would make sure no other residents were close to resident #002.

In an interview, staff #119 acknowledged there were no interventions developed and implemented for resident #002's previous described responsive behaviours.

In an interview, staff #115 stated residents' responsive behaviours would be discussed during the monthly behaviour rounds in relation to triggers and interventions. Staff #115 further stated that interventions for managing resident #002's previous described responsive behaviours should be included in the resident's written plan of care. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's responsive behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure where an incident has occurred that caused an injury to a resident for which the resident was taken to a hospital, and where the licensee determined that the injury has resulted in a significant change in the resident's health condition has informed the Director of the incident no later than three business days after the occurrence of the incident.

On an identified date, an identified CIS report was submitted to the MOHLTC. The CIS report indicated that five days prior, while the assigned primary staff member was providing care to resident #006 and heard a sound from their body. As a result of staff #116's assessment resident #006 was sent to hospital on the same day for further assessment.

A review of the documentation notes indicated resident #006 returned from hospital the next day with a diagnosis of an identified injury.

A review of CIS report indicated it had been submitted four days after the licensee had been informed of resident #006's injury.

During an interview, staff #123 acknowledged the home had not submitted the CIS report no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

Issued on this 1st day of March, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.