Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Jan 4, 2021	2020_808535_0015	014551-20, 019076-20	Critical Incident System

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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 16, 17, 18, 19, 20, 2020.

The following intakes were completed during this inspection: Log #014551-20, CIS#2970-000009-20 and log #019076-20, CI #970-000012-20, were related to falls prevention and management.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 6 (7) was identified in this inspection and has been issued in a concurrent inspection, #2020_808535_0014, dated November 23, 2020.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Physiotherapist (PT), registered staff (RN/RPN) and personal support workers.

During the course of the inspection, the inspector conducted observations of resident home areas and staff to resident interactions, reviewed clinical health records, treatment and medication administration records, staffing schedule, internal investigation notes and home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any devices or assistive aids used by the staff was appropriate for resident #004 based on the resident's condition.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #004's fall incident.

The resident used a mobility device and was isolated in their room. The resident's progress notes indicated that they experienced three unwitnessed falls on the floor in their room; and at the time of the third fall, the resident's mobility device was also found overturned on the floor. The resident was assessed and transferred to hospital for diagnosis and treatment which revealed an injury for which they were treated.

PSW #117 found the resident on the floor after the third fall, and stated that the resident likely tripped over the fall prevention device which was placed on the floor by their bed. RPN #106 verified that they saw the device on the floor when they assessed the resident, and that residents who ambulate with a mobility device should not have that fall prevention device at their bedside since that was a tripping hazard.

Source: Point Click Care (PCC) dash board and progress notes, interviews with PSW #117 and RPN #106 and other interviews. [s. 30. (1) 2.]

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 any devices or assistive aids used by the staff was appropriate for the resident and based on the resident's condition, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of residents #003 and #004's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A CIS report was submitted to the MLTC. The report indicated that resident #003 sustained a fall while ambulating on the unit. The resident was transferred to hospital for diagnosis and treatment which revealed evidence of an injury.

A review of the progress notes and an interview with the home's physiotherapist verified that a PT referral was not sent, and an assessment was not completed before or after the resident was transferred to hospital related to the fall incident.

Sources: CIS #2970-000012-20, resident #003's progress notes, interview with PT #102 and other staff. [s. 6. (4) (a)]

2. A CIS report was submitted to the MLTC. The report indicated that resident #004 sustained three falls when they were isolated in their room. The resident was transferred to hospital for diagnosis and treatment which revealed an injury for which they were treated.

A review of the progress notes and an interview with the home's physiotherapist verified that a PT referral was not sent, and an assessment was not completed before or after

each fall incident.

Sources: Resident #004's progress notes, interview with PT #102 and other staff. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #003 and #004 as specified in the plan.

Resident #003's plan of care indicated that the resident required limited assistance with one-person for ambulation on the unit. During the reported fall incident, the resident sustained an injury while they were ambulating independently and without assistance on the unit. The resident was transferred to hospital for diagnosis and treatment.

RPN #104 verified during the interview that resident #003 had an unwitnessed fall, and they were not provided with limited assistance by a staff as indicated in the plan of care.

Sources: CIS #2970-000012-20, resident #003's plan of care, interview with RPN #104 and other staff. [s. 6. (7)]

4. A review of resident #004's plan of care indicated that the resident required supervision for ambulation. The resident sustained three unsupervised falls on the floor in their room. After the third fall, the resident was assessed and transferred to hospital for diagnosis which revealed evidence of an injury.

RPN #106 verified that the resident's plan of care indicated the resident should have been supervised for ambulation; however it was difficult to supervise the resident since they were isolated in their room.

Source: Resident #004's 24-Hour care plan and progress notes, interview with RPN #106 and other interviews. [s. 6. (7)]

Issued on this 7th day of January, 2021

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

Original report signed by the inspector.