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

Original Public Report

Report Issue Date: August 9, 2023
Inspection Number: 2023-1453-0004
Inspection Type: Complaint Critical Incident System
Licensee: Broadview Foundation
Long Term Care Home and City: Chester Village, Toronto

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2023.08.11 10:47:46 -04'00'

Additional Inspector(s)
Noreen Frederick (704758)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 27, 28, 31, 2023 and August 1-3, 2023

The following intake was inspected in this complaint inspection:

- Intake: #00091062 - related to Infection Prevention and Control (IPAC), responsive behaviours, alleged abuse, and laundry and maintenance services

The follow intake was inspected in this Critical Incident System (CIS) inspection:

- Intake: #00087815 - [CI: 2970-000008-23] - related to a fall

The following intake was completed in this CIS inspection:

- Intake: #00088212 - [CI: 2970-000009-23] - related to a fall

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident had an altered skin integrity after an incident. The altered skin integrity was assessed weekly and this assessment was completed on Point Click Care (PCC). However, the scheduled weekly wound assessment was not completed for an identified period.

A Registered Nurse, who is the home's lead for skin and wounds, stated that the registered staff is responsible for completing the weekly wound assessment. A Registered Practical Nurse confirmed that the scheduled weekly wound assessment for an identified date was not signed on the TAR (Treatment Administration Record) and an assessment was not completed on PCC.

Failure to complete the weekly wound assessment can increase the risk for the staff's inability to assess the progress of the resident's altered skin integrity and determine further interventions.

Sources: Resident's Clinical Records; Interviews with RN and other staff; Resident Care Manual - Skin & Wound Care Program [000710]