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 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2016	2016_384161_0016	008285-16	Resident Quality Inspection

Licensee/Titulaire de permis

BROADVIEW NURSING CENTRE LIMITED
210 Brockville Street Smiths Falls ON K7A 3Z4

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

BROADVIEW NURSING CENTRE
210 Brockville Street Smiths Falls ON K7A 3Z4

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

KATHLEEN SMID (161), ANANDRAJ NATARAJAN (573), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 2, 3, 4, 5, 6, 2016.

During the course of the Resident Quality Inspection, the inspector(s) also conducted two concurrent inspections which included:

- One Critical Incident Inspection related to alleged staff to resident physical abuse.

- One Complaint Inspection related to pain management.

During the course of the inspection, the inspector(s) spoke with residents, family members, President of Resident Council, Personal Support Workers (PSW), RAI Coordinator, Registered Practical Nurses, Registered Nurses (RN), Maintenance staff member, Activity Director, Associate Director of Care (ADOC), Director of Nursing (DON) and the home's Administrator.

During the course of the inspection, the inspector(s) observed the delivery of resident care and services, resident rooms, resident common areas, infection control practices, medication administration and a meal service. The inspector(s) reviewed residents' health care records, salient home policies and procedures, programs, posted menus, staff work routines and Resident Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home's furnishings and equipment are kept clean and maintained in a good state of repair.

The following was observed by Inspector #573 in the resident common areas and resident rooms:

- One blue fabric couch and one pink fabric chair with dried yellow and white liquid stains on the seat and/or the frame.
- Wooden chairs with fabric cushions in four resident rooms with dried liquid stains on the cushion.
- Dining table wooden chair legs missing finish, the chairs have scuffed arms and legs.
- One pink fabric couch in the activity room with torn fabric on the left arm support of the couch.
- The wooden cupboard door in resident's larger tub room was worn off at the bottom, exposing the grain of wood and is chipped along the bottom edge of the door. In the same tub room the base board of the metal heater was missing and exposing the heating coil.
- In the smaller tub room the base board of the metal heater was rusted and dented exposing sharp edges. The floor tiles were missing near the drain hole exposing the sub floor.

On May 06, 2016, Inspector #573 observed the above identified housekeeping and maintenance issues in the presence of the home's Administrator. The Administrator agreed with the inspector that the above identified home's furnishings were not clean. Further the Administrator indicated to the inspector that she will follow up with her maintenance staff related to the identified maintenance issues in the resident tub rooms. [s. 15. (2) (c)]

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 the home's furnishings and equipment are not clean and maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the safety risks, with respect to the use of Assist- Rail for resident #003 and resident #043.

The Assist-Rail referred in this finding is an inverted U-style quarter bed rail for home beds. The Assist Rail provides assistance with bed mobility and self-transfers. The Assist rail is secured to the bed frame with mandatory safety straps, which will secure and hold the rail from shifting during use.

On May 02 and 04, 2016, Inspector #573 observed resident #003's bed system with one assist bed rail that was not firmly secured and no safety straps attached to the bed system. The assist rail was loose and leaving a gap of more than five inches between the rail and the bed frame that posed a safety risk and this had not been assessed.

Inspector #573 reviewed resident #003's health care record and there was no information in the health care record to indicate the use of the assist bed rail for the resident.

On May 04, 2016, Inspector #573 spoke with PSW #105 and the Associate Director of Care (ADOC), both indicated that they were not aware regarding the use of an assist rail for resident #003. Inspector #573 observed the resident #003's assist bed rail in the

presence of the ADOC who agreed that the assist bed rail was not firmly secured and attached to the resident bed system. The Assist rail was immediately removed from the resident #003's bed system by the ADOC.

Inspector reviewed resident #043's health care record which indicates resident requires the use of one short assist bed rail for bed mobility.

On May 04, 2016, Inspector observed resident #043's bed system with no assist rail attached to the bed system. Inspector #573 spoke with PSW #105 who indicated that the assist rail was provided by the resident #042's daughter. Further the PSW #105 indicated that few days before she removed the assist rail from the resident's bed system, since resident #043 exhibited responsive behaviors like agitation during bed time.

On May 04, 2016, Inspector #573 discussed with the ADOC regarding the potential safety risk related to the use of assist rail. The ADOC indicated that an assessment for the need of assist rail and an interdisciplinary assessment for potential safety risk associated with the use of assist rail were not done prior to the application of the assist rails for the resident #003 and resident #043. [s. 26. (3) 19.]

Issued on this 10th day of May, 2016

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

Original report signed by the inspector.