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
Mar 11, 2019	2019_625133_0004	004544-19, 004545-19	Complaint

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

JESSICA LAPENSEE (133)

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): March 7, 2019

The following intakes were completed in this Complaint inspection: Log # 004544-19 and Log #004545-19 were related to water leaking from the ceiling.

It is noted that, related to the same matter, a field visit was conducted at the home by an Occupational Health & Safety Inspector with the Ontario Ministry of Labour on March 7, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Maintenance, registered and non-registered nursing staff, and a Ministry of Labour Inspector.

During the course of the inspection, the inspector observed the areas affected by the leaking, reviewed a roofing inspection invoice from June 2018, and reviewed a Ministry of Labour field visit report that was provided to the Administrator on the afternoon of the inspection day.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **1 WN(s)**
- **0 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours.

The Ministry of Health and Long Term Care (MOHLTC) received two complaints on an identified date in 2019 (the second day), with regards to water leaking from the ceiling of the home.

On February 28, 2019, the information provided to the Inspector by the Administrator, the Director of Maintenance, the Director of Care and Nursing Staff (#104, #105, #106) indicated that water started leaking from the ceiling in an identified area on the day before the complaints were received by the MOHLTC in 2019 (the first day). The amount of water leaking from the ceiling escalated over two days, due to outdoor temperatures above freezing, and a prolonged rain event that began on the second day. Water saturated ceiling tiles were taken down, throughout an identified hallway area. Large containers were used in an effort to collect the dripping water throughout the identified hallway area. Absorbent items were used on the floor around the containers to catch water that was splashing out. Residents whose rooms are located in the identified hallway were required to navigate around the containers and absorbent items on the floor, to travel to and from their bedrooms and common areas such as the dining room and the front lounge. Nursing Staff #104, #105 and #106 indicated that one resident's (#001) bedroom was affected by this event as well, on the evening of the second day, with water coming into the room from underneath the baseboard within the entrance area. Nursing staff closed resident #001s bedroom door to prevent them from entering the room. Arrangements were made for the resident to rest as required in an alternative location. The leaking slowed and then ceased in all identified areas by mid-day, on the third day, as the rain stopped and outdoor temperatures returned to below freezing.

The environmental hazard presented a potential risk to all residents who reside in hallway number two. The environmental hazard occurred for a period of greater than six hours. The Director was not informed of the environmental hazard. [s. 107. (3) 2.]

Issued on this 11th day of March, 2019

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

Original report signed by the inspector.