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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
May 8, 2019	2019_702197_0010	002662-19	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 PATTISON (197)

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): April 8-10 (on-site), April 15, 24 and 29 (off-site), 2019

Log 002662-19 is related to a complaint about the medical and nutritional care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, a Physician, a Registered Dietitian, the Clinical Care Coordinator, the Coroner, Registered Nurses, Registered Practical Nurses, Personal Support Workers and a family member of a resident.

The inspector also reviewed a resident's health care record and policies related to admission and medication reconciliation.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #001 was admitted to the home with a specified diagnosis.

In the admission paperwork sent to the home there was a hospital discharge summary which indicated that the resident had been hospitalized during a specified time period and that a referral was being made to provide close nursing follow-up and assistance with self-care of their specified diagnosis.

Also in the admission paperwork was an initial assessment by a particular clinician, which gave specific instructions related to the diagnosis.

An interview was conducted with RN #100 who completed the admission of resident #001. The RN stated that they did not recall any information related to the resident's specific diagnosis and treatment in the admission paperwork. They stated that if they had seen this information, they would have put it on top of the MAR (Medication Administration Record) and notified the related department.

The Registered Dietitian (RD) in the home completed an admission assessment for resident #001. In this assessment, they referred to a specific intervention in the past for one of the resident's diagnoses, but did not direct staff to implement that intervention at the time. During a telephone interview with the RD, they indicated that they had not implemented the specified intervention for resident #001 and was not aware that resident

had been receiving this intervention just prior to coming to the home. The RD did state that the resident mentioned to them that they had been on the specified intervention in the past but that the resident could not recall the exact details.

Physician #102 wrote a progress noted indicating they had seen resident #001 on a specified date and that they had reviewed the patient and their chart. The note stated that the resident had a history with a particular diagnosis and wanted certain interventions in place. During a telephone interview with Physician #102, they stated they had not ordered the requested interventions at the time since they prefer not to make drastic changes when a resident first comes to long-term care. When asked if they were aware the resident had been receiving the specified interventions before coming to the home, they stated they were not aware of this and felt that this information should have been included for them to review upon admission. The Physician clarified that it was their understanding that the resident was interested in these specified interventions, not that they were already in place before the resident was admitted to the home.

The inspector reviewed the plan of care (paper and electronic) for resident #001 and found no evidence that staff had seen or discussed the assessment that was included in the admission paperwork that was sent to the home prior to the resident's admission. Documented assessments and progress notes in the home indicated that the resident had mentioned receiving a specified intervention prior to admission and wanting certain interventions to continue in the home, but there was no evidence that staff had collaborated with each other in their assessments of resident #001 to ensure they were integrated, consistent with and complemented each other. [s. 6. (4) (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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 28th day of May, 2019

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

Original report signed by the inspector.