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
Dec 22, 2020	2020_520622_0022	022733-20	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

HEATH HEFFERNAN (622)

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): November 23,24, 25, and December 1, 2, 3, 4, 7, 8, 9, 10, 2020.

The following intake was completed in this Complaint Inspection:

Log # 022733-20, IL-84609-OT related to resident care and services.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), the Perth and Smiths Falls District Hospital Privacy and Patient Relations Manager, the Perth and Smiths Falls District Hospital Nurse Manager, Registered Nurses (RNs), Personal Support Workers (PSWs).

Also during the inspection, the inspector reviewed pertinent health records, the Licensee's policy and procedure related to urinary tract infections.

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

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

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

Progress notes indicated that a resident had a significant change of condition noted by registered staff on a date in November 2020. The Physician was not notified of the significant change until the following day when the resident had a further decline in their condition and required a transfer to the hospital.

The Registered Nurse (RN) stated that they had not notified the physician when the resident had a significant change in their condition on that date in November 2020.

Sources: the resident's progress notes; and interviews with the RN and other staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure that a resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's Power of Attorney (POA) was aware of the resident's history and symptoms

of a specific infection. On a date in October 2020, they had noted a change in the resident and requested a specimen be completed. The registered staff informed them that a specimen would be done however the specimen was not completed until 4 days later. The specimen results indicated that the resident had an infection and they were ordered a specific treatment 8 days after the request of the specimen from the POA.

The Registered Practical Nurse (RPN) who spoke with the resident’s POA on the date in October 2020 stated that they had assured the POA that they would follow the home's policy and a specimen would be taken.

Furthermore, the resident was noted on a date in November 2020, to have a significant change in their condition.

Progress notes did not indicate that the resident's POA had been notified.

The RN stated that they had not notified the resident’s POA of the significant change in their condition that date.

Sources: the resident’s progress notes; and interviews with the DOC, the RN and other staff. [s. 6. (5)]

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

and

to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 24th day of December, 2020

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

Original report signed by the inspector.