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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 28, 2023
Inspection Number: 2023-1185-0006
Inspection Type: Complaint Critical Incident
Licensee: Broadview Nursing Centre Limited
Long Term Care Home and City: Broadview Nursing Centre, Smiths Falls

Lead Inspector	**Inspector Digital Signature**
Polly Gray-Pattemore (740790)	Pauline L Gray Pattemore Digitally signed by Pauline L Gray Pattemore Date: 2023.12.01 08:12:55 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 18, 23-25, 30-31 and November 1-2, 2023

The following intakes was completed in this complaint inspection:

- Intake #00095099 and #00095343 was related to alleged abuse and neglect, medication management, training, retaliation, emergency plans, equipment, and reporting of abuse and neglect.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00095089/CI#2684-000010-23 was related to choking.
- Intake #00099120/CI#2684-000014-23 was related to fall prevention and management.

- Intake #00100329/CI#2684-000015-23 was related to fall prevention and management.
- Intake #00095155/CI#2684-000011-23 was related to a complaint of alleged financial abuse.
- Intake #00095166 /CI#2684-000012-23 was related to a complaint of alleged emotional abuse.

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

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that staff to resident abuse had occurred, immediately reported the

suspicion and the information upon which it was based to the Director.

Rationale and Summary:

During an interview with staff #101, they acknowledged that they received a call from staff #119 who informed them of alleged abuse by staff to a resident, and that the licensee did not immediately contact the MOHLTC's after hours emergency pager.

During an interview with the resident, they recalled that they had reported to staff an alleged incident of abuse. A review of the licensee's abuse and neglect policy indicates that any person who has reasonable grounds to suspect abuse of a resident by anyone, or neglect of a resident by licensee or staff member that results in harm or risk of harm to a resident has occurred shall immediately report the suspicion and the information upon it was based to the Director.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to alleged abuse by staff to the resident. A review of the licensee's Complaints/Concerns Logs 2023, indicates that the licensee received a complaint related to the alleged abuse by staff to the resident. A review of licensee's internal investigation file included a letter related to the alleged abuse by staff to the resident.

By not reporting allegations of staff to resident abuse, places the residents at risk for ongoing situations of alleged abuse.

Sources: licensee's Abuse and Neglect Policy, Index I.D.: P-10, page 1 of 11, original date: December 19, 2000, reviewed date: June 15, 2023; letter; licensee's Complaints/Concerns Logs 2023; interview with resident; and interview with staff.

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WRITTEN NOTIFICATION: Dealing with complaints.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

A) Rationale and Summary:

The licensee responded to a written complaint. Review of the response provided to the person who made the complaint, shows that the licensee did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010. During an interview with staff, they acknowledged they were unaware to include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

By not including this information in the response letter to a complainant, places a risk of future submission of urgent and non-urgent reporting to the Ministry and contact to the patient ombudsman if the complainant was not able to reach a satisfactory resolution.

Sources: licensee response provided to the person who made the complaint; and

interview with staff.

B) Rationale and Summary:

The licensee responded to a written complaint. Review of the response provided to the person who made the complaint, shows that the licensee did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010. During an interview with staff, they acknowledged they were unaware to include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

By not including this information in the response letter to a complainant, places a risk of future submission of urgent and non-urgent reporting to the Ministry and contact to the patient ombudsman if the complainant was not able to reach a satisfactory resolution.

Sources: licensee response provided to the person who made the complaint; and interview with staff.
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