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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2017	2017_520622_0018	005609-17	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): June 07, 08, 2017

The following logs were completed as part of this inspection:

Critical Incident System (CIS) report related to an incident with injury/hospital transfer/significant change in status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the RAI Coordinator, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

Also during the course of the inspection the inspector observed resident care and services and reviewed resident health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has been reassessed and the resident's care needs change or care set out in the plan is no longer necessary the plan of care has been revised.

The CIS report indicated on a specified date resident #001 fell, sustained an injury and was transferred to the hospital. A review of the home's documentation on point click care which included, the falls risk assessments and the post fall assessments indicated resident #001 was identified at risk for falls and had sustained multiple falls in a specified time frame.

Review of the most recent care plan for resident #001 indicated the care plan had been updated to include an intervention on a specified date.

On a specified date, inspector #622 reviewed the post fall assessments for resident #001 with the ADOC. The post fall assessments indicated the specific intervention was not being used during a specific number of resident #001's falls which occurred on specified dates.

A review of the home's checklist pertaining to the specific intervention with the ADOC indicated resident #001 was not included in the documents in a specific period of time. At the time of the review, the ADOC indicated the checklist would not include resident #001 because the specific intervention was no longer being used due to upset to the resident.

During separate interviews, the ADOC and DOC indicated when there has been a change in a resident or an intervention on the care plan has been ineffective, it is the responsibility of the registered staff and nursing management to reassess the care plan. The DOC stated the RAI Coordinator would be responsible to revise the care plan when it had been assessed for change. The ADOC and DOC indicated the care plan for resident #001 had been reassessed and numerous interventions had been trialled to prevent resident #001 from falling. Both the ADOC and DOC stated that resident #001 had been trialled with the specified intervention however the intervention was ineffective. Furthermore the ADOC and DOC indicated the specific intervention was no longer being used and should have been removed from resident #001's care plan as it had been noted to be ineffective.

Therefore the licensee has failed to ensure that the care plan was revised when resident

#001 was reassessed and the resident’s care specific to the use of an intervention for falls prevention was ineffective and no longer necessary. [s. 6. (10) (b)]

Issued on this 9th day of June, 2017

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

Original report signed by the inspector.