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 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 28, 2022
Inspection Number: 2022-1185-0001
Inspection Type: Complaint Critical Incident System
Licensee: Broadview Nursing Centre Limited
Long Term Care Home and City: Broadview Nursing Centre, Smiths Falls

Lead Inspector	**Inspector Digital Signature**
Heath Heffernan (622)	Heath Heffernan Digitally signed by Heath Heffernan Date: 2022.11.29 15:52:41 -05'00'

Additional Inspector(s)
Ashley Bernard-Demers (740787)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 26, 27, 28, 29, 30, 2022 and October 3, 4, 5, 6, 7, 11, 2022.

The following intake(s) were inspected:
• Complaint intake: #00001882- [IL: 03144-OT] related to resident care and services, maintenance services, and air temperatures.
• Complaint intake: #00002091- related to maintenance services and air temperatures.
• Critical Incident intake: #00005278 - related to a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.
• Complaint intake: #00006235- [IL: 05176-OT] - related to a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition, resident care and services and maintenance services.

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

Falls Prevention and Management
Infection Prevention and Control
Housekeeping, Laundry and Maintenance Services
Continence Care
Safe and Secure Home
Pain Management
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (8)

During the initial tour of the home on September 26, 2022, inspectors #622 and #740787 observed that 16 of the hand sanitizers that were in circulation had expired.

During an interview with inspector #622 on September 26, 2022, the Administrator stated that it was the responsibility of the Infection Prevention and Control Lead to ensure that expired hand sanitizers were removed. They stated that they would ensure that all expired hand sanitizers would be changed out.

On September 29, 2022, Inspectors #622 and #740787 observed that all 16 of the expired hand sanitizers were removed from circulation within the home.

Date Remedy Implemented: September 29, 2022
[622]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 12. (1) 3.

The licensee has failed to ensure that the janitor room door was kept closed and locked when not being supervised by staff.

Rationale and Summary
On September 26, 2022, inspector #622 observed the janitor room door in resident hallway 2 was left propped open. The room contained a floor scrubber and multiple cleaning chemicals. No staff were in the immediate area supervising the room.

During an interview with inspector #622 on September 26, 2022, a housekeeper stated that the janitor room door should not have been left open and closed it immediately.

Leaving the janitor room door open and unsupervised, allowed access to multiple cleaning chemicals, placing the residents at risk.

Sources: observation of the janitor room door and interview with housekeeper.
[622]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 115. (3) 4.

The licensee has failed to ensure that the Director was informed of an incident that caused injury to a resident, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

Rationale and Summary
Review of the progress notes on point click care, indicated that on date in July 2022, a resident fell and

sustained injuries. The resident was transferred to the hospital for assessment, their health condition was impacted requiring the use of a specialized device, and pain management because of the fall.

Review of the critical incident reporting system indicated that the licensee had not reported the resident's fall incident with hospital transfer and significant change in their health condition to the Director.

Sources: Review of resident's progress notes, critical incident reporting system, and interview with the Administrator and other staff.
[622]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40.

The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting a resident.

Rationale and Summary
A resident's current plan of care stated that a specific mechanical device using two staff was required for all transfers.

During separate interviews, two Personal Support Workers (PSWs) stated that the resident was supposed to use a specific mechanical device for all transfers however, the device was broken. One of the PSWs stated that due to the device being broken, they had performed a transfer on the resident without a mechanical device and their legs buckled during the transfer.

During an interview, the Clinical Manager stated that PSWs have the ability for safety purposes to move up a level on a lift or transfer, they can never move down unless there has been an assessment by a Registered Nurse. Since the specific mechanical device was broken, staff were given the direction to increase all residents requiring the specific mechanical device to a full mechanical lift.

Failure to use safe transferring devices and techniques when assisting the resident, placed the resident at increased risk of injury.

Sources: Review of the plan of care and interview with the PSW and other staff.
[622]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 54 (1)

The licensee has failed to ensure that the home's organized Falls Prevention and Management program was complied with.

Rationale and Summary
Specifically, the staff did not comply with the licensee's policy #: I.D.: E-35 - Resident Safety - Head Injury Routine - Reviewed Date: February 16, 2022, which stated that the resident would be closely observed, assessed, and vital signs would be monitored according to established guidelines, subsequent to a head injury or suspected head injury as follows:

Vital signs were to be checked and recorded for 48 hours as follows:
- every one-hour for the first four hours.
- every two hours for the next four hours.
- every four hours for the next sixteen hours.
- every eight hours for the next twenty-four hours.

The head injury routine document related to a fall that a resident sustained on a date in July 2022, was not completed twice during the forty-eight-hour assessment timeframe.

During an interview, the Clinical Manager stated that the head injury routine should have been completed unless refused by the resident.

There was no documentation to indicate that the resident had refused a head injury routine assessment.

Sources: Review of the licensee's policy #: I.D.: E-35 - Resident Safety - Head Injury Routine, resident's head injury routine, progress notes, vital signs, and interview with the Clinical Manager and other staff.
[622]

WRITTEN NOTIFICATION: 24-hour Admission Care Plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 27. (6).

The licensee has failed to ensure that the care set out in resident's 24-hour admission care plan related to transferring was provided as specified in the plan.

Rationale and Summary
On a date in August 2022, a RPN attempted to perform a transfer with a resident who sustained a fall as a result.

The resident's 24-hour admission care plan gave specific instructions for safety during all transfers.

During an interview, the Administrator stated that the RPN had attempted to transfer the resident on their own when they should have followed the resident's specified instructions for transfers.

Sources: The resident's health records including risk management notes, progress notes, 24-hour admission care plan and interview with the Administrator and other staff.
[622]

COMPLIANCE ORDER CO #001 24-hour admission care plan

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 27 (6)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The Licensee has failed to comply with O. Reg. 246/22, s. 27. (6).

The licensee shall:

1) Ensure that the resident and any other residents who require the use of an assistive device, have been assessed for its use and that the assistive device has been added to their plan of care.

2) Until this order has been complied, keep a record of the residents using the assistive device in the home, the specific assistive device being used for each resident and the date each resident was assessed for the use of the assistive device.

3) Provide education to the Personal Support Worker (PSW) specific to the record of the residents using

the assistive devices in the home, the specific assistive device being used for each resident and the number of staff required for the process of toileting.

4) Document the contents of the education including the date, the attendee's name, and the staff member who provided the education.

Grounds
Non-compliance with: O. Reg. 246/22 s. 27. (6)

The licensee has failed to ensure that the care set out in a resident's 24-hour admission care plan related to toileting was provided as specified in the plan.

Rationale and Summary
A resident fell in the washroom on a date in July 2022, and sustained injury.

The 24-hour admission care plan for the resident included directions for the level of assistance throughout the entire process of toileting and did not include the use of an assistive device.

During an interview, a PSW stated that when the resident fell on the date in July 2022, they were using an assistive device belonging to a co-resident. The PSW also stated that they were alone with the resident in the washroom at the time of the fall.

During an interview, the Clinical Manager stated that the resident was placed at risk, fell, and sustained injury when staff did not comply with the 24-hour admission care plan.

Sources: The resident's health records including: progress notes, risk management notes, 24-hour admission care plan, and interview with the PSW and other staff.
[622]

This order must be complied with by February 14, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.