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

Original Public Report

Report Issue Date: June 27, 2023	
Inspection Number: 2023-1185-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Broadview Nursing Centre Limited	
Long Term Care Home and City: Broadview Nursing Centre, Smiths Falls	
Lead Inspector Cheryl Leach (719340)	**Inspector Digital Signature** Cheryl Leach Digitally signed by Cheryl Leach Date: 2023.06.27 10:23:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 2, 8, 9, 12, 13, 14, 15, 2023

The following intake(s) were inspected:

- Intake: #00086439-[IL-12491-AH/CI 2684-000005-23] Resident to resident sexual abuse.
- Intake: #00087064-[IL-12771-OT] Family concern regarding care and services.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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)
FLTCA, 2021, s. 26 (1) (b)

Findings of Non-Compliance were found during this inspection and were remedied prior to its conclusion. The inspector was satisfied that the non-compliance met the intent of FLTCA 2021 s.154 (2) and requires no further action.

FLTCA 2021 s. 26 (1) b

Non-compliance
On June 15, 2023 the admission packet was received from Administrator #100 and was noted to have the incorrect address for the Ministry pertaining to the complaints process.
Remedy
On June 15, 2023 the admission packet was updated by Administrator #100 to reflect the current address for the Ministry pertaining to the complaints process.
There was low risk to the residents due to the mailing address for the Ministry pertaining to the complaints process being incorrect.

Sources
Admission packet, interview with Administrator #100.

[719340]

Date Remedy Implemented: June 15, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective related to resident to resident sexual responsive behaviours.

Upon review of progress notes and Risk Management, it was noted that sexual responsive behaviours were exhibited three times between two residents. The plans of care for these residents were not revised at the time of these incidents. As per interviews with Registered Nurse (RN) and Personal Support Workers (PSW's) there were no additional interventions or changes to current interventions put into place at the time of these incidents. Failure to ensure that the plan of care is reviewed and revised when not effective places residents at increased risk of harm.

Sources:
Critical Incident, Risk Management, progress notes and care plans for residents, interviews with RN and PSW's.

[719340]