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
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Ottawa, ON, K1S 3J4
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Public Report

Report Issue Date: May 29, 2025

Inspection Number: 2025-1185-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Broadview Nursing Centre Limited

Long Term Care Home and City: Broadview Nursing Centre, Smiths Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13, 14, 15, 16, 20, 21, 22, 26, 27, 2025

The following intake(s) were inspected:

- Intake: #00139083 (CI #2684-000001-25) - Enteric outbreak
- Intake: #00142829 (CI #2684-000004-25) - An allegation of staff to resident verbal and physical abuse
- Intake: #00142337 - Follow-up #: 1 - O. Reg. 246/22 - s. 12 (1) 3. in regards to doors to non-resident areas
- Intake: #00142338 - Follow-up #: 1 - O. Reg. 246/22 - s. 24 (1) in regards to air temperatures
- Intake: #00147535 - A complaint regarding resident personal care and bathing

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1185-0001 related to O. Reg. 246/22, s. 12 (1) 3.
Order #002 from Inspection #2025-1185-0001 related to O. Reg. 246/22, s. 24 (1)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

The licensee has failed to ensure that the number of staff members and residents

affected by an Enteric outbreak was reflected in the Critical Incident (CI) submission to the Director.

Sources: CI #2684-000001-25, outbreak line listing, progress notes, interviews with the Infection Prevention and Control lead and the Administrator.

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