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

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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
Dec 1, 2016	2016_536537_0041	031048-16	Resident Quality Inspection

Licensee/Titulaire de permis

BABCOCK COMMUNITY CARE CENTRE INC.
196 Wellington Street P.O. Box 190 Wardsville ON N0L 2N0

Long-Term Care Home/Foyer de soins de longue durée

BABCOCK COMMUNITY CARE CENTRE
196 Wellington Street P. O. Box 190 Wardsville ON N0L 2N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NANCY SINCLAIR (537), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 24, 25, 2016

The following intake was completed within the RQI:
Log #024969-16/CI 2626-000006-16 related to alleged abuse to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Services Supervisor, Quality Improvement Registered Nurse, Registered Dietitian, Activity Director, Resident Assessment Instrument (RAI) Coordinator, three Registered Nurses, two Registered Practical Nurses, six Personal Support Workers, Residents' Council Representative, Family Council Representative , residents and families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, meeting minutes and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 the care plan was reviewed and revised when the resident was reassessed and the care needs changed.

Observation of and identified resident revealed the use of a restraint.

During an interview with Personal Support Worker (PSW) #104, the PSW stated that the use of a restraint for a resident was included in the care plan that could be accessed on the Point of Care (POC) portal for each resident and that the home used a symbol so staff could quickly identify the resident was authorized to use a specific restraint.

During an interview with Personal Support Worker #103, the PSW stated that they just knew which residents used restraints and who did not, but a review of the care plan on POC would provide the information if they did not know. PSW #103 stated that they were not aware of the use of a symbol or what it would represent. PSW #103 stated also that changes to the use of a restraint for a resident would be indicated in the communication book and discussed at shift report. They stated the use of the restraint for the identified resident.

Record review for the resident contained a physician order with specific instructions for the use of the specific restraint.

The care plan for this resident included instructions for the use of the specific restraint in two different focuses, neither focus being the specific instructions identified by the physician order.

During an interview with the Director of Care (DOC) #104, they stated that the use of the restraint for the identified resident had recently changed as per the direction of a physician order . She stated that the home used a symbol for a quick reference for staff to indicate that a resident was authorized to use a specific restraint, that the information was communicated to staff at report using the communication book for new or changes in direction, that the care plan was created or updated to reflect the information. Observation of the identified resident did not include the symbol to indicate to staff the use of a specific restraint. The care plan also did not include the correct information regarding the use of the restraint from the most recent physician order.

The DOC stated that the care plan should have been reviewed and revised when the care needs of the resident changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home, (a) completed a nutritional assessment for all residents on admission and (b) assessed matters related to nutritional status including height, weight and any risks relating to nutritional care.

Review of the clinical record for an identified resident revealed no documentation of a nutritional assessment, including the identification of a desirable weight range, completed by the RD of the home at the time of admission or at any other time.

Review of the home's policy titled "Nutritional Risk Indicators" effective date May 2014, stated "the Registered Dietitian (RD) will assess each new resident to determine the classification of nutritional risk and the priority of nutritional care interventions and recommendations within 14 days of admission".
Review of the home's policy titled "Weight Monitoring" effective date April 2015, stated "the RD will be responsible to determine the desirable weight range for each resident" and "this ideal will be documented on the admission nutritional assessment".

Food Services Supervisor (FSS) #107 stated that the practise in the home for the nutritional assessments of residents newly admitted included a dietary profile completed by the FSS, a nutritional assessment documented as a progress note completed by the RD and the "Nutritional and Hydration Risk Identified Tool" completed by the RD. FSS #107 reviewed the clinical record for the identified resident and acknowledged that a nutritional assessment had not been completed by the home's RD at the time of admission or at any time since admission. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in the resident's health condition, and assesses matters related to nutritional status including height, weight and any risks relating to nutritional care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident with a weight change of 5 per cent body weight or more over one month was assessed using an interdisciplinary approach and that actions were taken and outcomes evaluated.

Review of the clinical record for an identified resident found this resident experienced a weight change of 5 per cent or more in one month. Further review of the electronic record identified no documentation of a nutritional assessment by the interdisciplinary team regarding the change in weight or actions taken regarding the weight change.

Review of the home's policy titled "Weight Monitoring" effective date April 2015, stated "where a significant weight change has been determined the nursing staff shall notify the RD and FSS by written referral" and "all weight discrepancies shall be referred to the RD for assessment".

FSS #107 stated that when a resident had a significant weight loss a referral was to be made to the RD for an assessment to be completed. FSS #107 reviewed the clinical record for the identified resident and acknowledged that this resident had experienced a significant weight loss and there was no documentation of an assessment having been completed or actions taken in regards to this change. FSS #107 also identified that there had been no referral made to the RD by the nursing staff or the FSS for resident #001 regarding this weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that a resident with a weight change of 7.5 per cent

of body weight, or more, over three months had been assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Review of the clinical record for an identified resident revealed a weight loss of 7.5 per cent over three months. The resident was assessed on admission by Registered Dietitian #113.

Interview with the Food Services Supervisor (FSS) #107 revealed that the FSS #107 had completed a quarterly dietary assessment for the identified resident prior to the date when the significant weight loss had been identified. FSS #107 stated that they would review the weights for this resident at the next quarterly review. FSS #107 stated that the resident would be not be scheduled for a review before the next quarterly review date and they would send a referral to the dietitian at that time if the Quarterly Dietary Assessment indicated a need for reassessment by the Registered Dietitian (RD). FSS # 107 acknowledged that this assessment was not scheduled two months. FSS #107 also stated that the monthly weights were reviewed by either the FSS or by the Quality Improvement Nurse for completeness, but that significant weight changes should be identified by the Registered staff who inputted the weight into the computer, and a referral should be sent to the FSS or to the Registered Dietitian.

Interview with the Quality Improvement Nurse #111 revealed that the monthly weights were monitored for completeness and the Personal Support Workers were asked to complete a weight on any missed weights. The Quality Improvement Nurse indicated that part of the review did not include monitoring for weight changes, and that the expectation was that the Registered Staff who inputted the weights were responsible for requesting a reweigh for any discrepancies and then completing a referral to the FSS or the RD if there continued to be a weight change.

Interview with the Registered Dietitian (RD) #113 revealed that the FSS did complete the quarterly review for specific residents and it was expected that noted weight changes of 5%. 7.5% or 10% as per the LTCHA would be forwarded for review by the RD at the time of the weight change, and should not be left until an upcoming assessment date.

The home's policy titled "Weight Monitoring" 3.280, last reviewed in April 2015, indicated that "Where a significant weight change has been determined the Nursing staff shall notify the RD/FSS by written referral."

Review of the referral form titled "Notification of Diet Order Change or Nutritional Status

Change" did not include a 7.5% weight change on the referral form.

Interview was conducted with Registered Nurse (RN) #116 who stated that if they noted a discrepancy in a weight, they would ask staff to complete a reweigh. RN #116 stated that if they received a reweigh and found there still to be a discrepancy in the weight, that they would write it in the doctors book.

The Director of Care #106 and the Food Services Supervisor #107 stated that a resident with a weight change of 7.5 per cent of body weight, or more, over three months had not been assessed using an interdisciplinary approach, and that actions were not taken and outcomes were not evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent body weight, or more, over one month.
2. A change of 7.5 per cent body weight, or more, over three months, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping that procedures were developed and implemented for the cleaning and disinfection of devices including personal assistance services devices, assistive aids and positioning aids.

Observations of an identified resident revealed the mobility equipment for an identified resident had debris, dust and dirt on it.

Registered Nurse (RN) #111 stated that the schedule for cleaning of mobility equipment was documented electronically in Point Click Care (PCC). RN #111 said that the cleaning of the mobility equipment was scheduled for the night before the resident's bath and the staff look in PCC to identify which residents had equipment that needed to be completed on the night shift. RN #111 reviewed the tasks section in Point of Care (POC) for the identified resident and revealed that the cleaning of the mobility equipment for this resident had been set up as "as needed" and acknowledged that it had not been signed off in the past 14 days as having been cleaned. RN #111 reviewed the bath list and identified that the mobility equipment should have been cleaned on the night shift.

RN #111 acknowledged that the mobility equipment was not clean when observed.

Review of the home's policy titled "Procedure for sanitizing wheelchairs, geriatric chairs, walkers and canes" with effective date October 2012, indicated "all charting for wheelchair, walker and geriatric chair cleaning is documented on Point of Care system".

DOC #106 reported that the process in the home for the cleaning of mobility equipment was for them to be cleaned by a designated staff person on the night shift based on the scheduled tasks in PCC. DOC #106 reported that the staff person who completed the cleaning would document in POC. She indicated that it was the expectation in the home that the mobility equipment would be cleaned and documented as per this policy and process in home. [s. 87. (2) (b)]

Issued on this 1st day of December, 2016

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

Original report signed by the inspector.