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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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130 avenue Dufferin 4ème étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2017	2017_531518_0028	014745-17	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

ALISON FALKINGHAM (518), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 17, 18, 19, 20 and 21, 2017

Also inspected within this Resident Quality Inspection:
Log # 003962-17 CIS 2626-000001-17 related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), three Registered Nurses(RN), three Registered Practical Nurses, the Food Service Manager, the Maintenance Supervisor, one housekeeper, four Personal Support Workers, the Resident Council President, twenty residents and three resident family members.

The Inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records of twenty residents, and plans of care for identified residents were reviewed. Inspectors observed a medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and general maintenance, cleanliness and condition of the home.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 VPC(s)
1 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During an interview the resident said that the pain was continuous and had been increasing over time. The resident said that the medication was not always working and that they asked for as needed (PRN) medication.

A review of the physician's current order showed that the resident was prescribed an analgesic two tablets by mouth daily and every four hours as needed and a second analgesic tablet daily in the morning.

A review of the resident's clinical record showed that registered staff had documented when the resident experienced pain, when the medication was administered and the effectiveness of the medication, however there was no documented evidence of a pain assessment completed since the resident's admission.

The inspector reviewed the resident's electronic Medication Administration Record (eMAR) which showed the resident had received the daily scheduled analgesics for pain and had received PRN analgesics for breakthrough pain on a regular basis as requested by the resident.

Review of the home's Pain Assessment and Management Policy reviewed October 2012 stated "Each resident must have a formal pain assessment on admission and be re-assessed on re-admission, quarterly, and at least every shift. Residents experiencing pain must be treated immediately using non-pharmacological and pharmacological

methods to maximize function and promote quality of life". "Nursing (RN and RPN): Conducts and documents a pain assessment, on admission, re-admission, quarterly, initiation of a pain medication or prn analgesic, resident states pain severity is a 4/10 or greater, diagnosis of painful disease, resident/family/staff/volunteers indicate pain is present, initiates a pain management flow record when a schedule pain medication does not relieve the pain or when pain remains regardless or interventions".

During an interview a registered staff member stated that "beside the three months review we don't do pain assessments with the residents" and that this resident had been having pain since their admission.

During an interview a registered staff member stated that the resident had pain and no pain assessment was completed, that the resident's care plan did not reflect the current pain the resident was experiencing and that it would be the home's expectation to have pain identified in the care plan.

During an interview two registered staff members stated that the resident had moderate to severe pain at multiple sites on their body and that the resident was using analgesics regularly. Both registered staff members also stated that there were no pain assessment completed for this resident or any resident since their admissions, that the care plan did not reflect the actual pain the resident was experiencing and that the home's expectation was that when a resident experienced pain, a pain assessment should be completed and that the care plan should reflect the resident's needs for pain relief. [s. 52. (2)]

2. During an interview the resident had stated that they experienced pain.

A review of the physician's current orders showed that the resident was prescribed an analgesic two tablets, three times a day and every four hours as needed for pain and or fever.

A review of the resident's clinical record showed that registered staff were documenting when the resident was experiencing pain, the medication administrated and the effectiveness of the medication.

There was no documented evidence of a pain assessment completed since the resident's admission and the resident's care plan made no mention of the resident experiencing pain.

During an interview two registered staff members stated the resident did not express pain often, however they felt the resident may experience pain when moved. The resident was on a regular dose of analgesics and they felt that this medication was helpful. The two registered staff members also stated the resident's care plan made no mention of the resident experiencing pain. Both staff members stated that no pain assessments were completed for the resident, and that the home's expectation was that a pain assessment should be completed.

During an interview a registered staff member stated that the resident was experiencing pain and was receiving analgesics regularly. The registered staff member said that no pain assessment was completed for that resident or any resident since admission and that there was no care plan for the resident's pain. The staff member also stated that the home's expectation was that when a resident experienced pain, a pain assessment should be completed and care planned. [s. 52. (2)]

3. During an interview the resident told the inspector that they experienced pain. The resident shared that the pain never goes away and it was increasing with time.

A review of the physician's current orders showed that the resident was prescribed an analgesic two tablets, three time a day, a different analgesic, one tablet twice daily and a third analgesic two tablets daily and two tablets every six hours as required for pain.

A review of the resident's clinical record showed that registered staff were documenting when the resident was experiencing pain, the medication administrated and the effectiveness of the medication.

The inspector reviewed the resident's electronic Medication Administration Record (eMAR) which showed the resident had received the daily scheduled analgesics for pain and had received PRN analgesics for breakthrough pain on a regular basis as requested by the resident.

A review of the resident's clinical records found no documented evidence of a pain assessment completed since the resident's admission.

During an interview a registered staff member said that the resident had a lot of pain due to a medical condition. The registered staff member stated that no pain assessment was completed for the resident even though the resident was on regular pain medication and PRNs.

During an interview two registered staff members stated that the resident had a lot of pain due to a medical condition and was taking a lot of analgesics for it. Both said that no pain assessment had been completed for the resident since their admission or for any other resident in the home, and that the resident's care plan did not reflect the actual pain the resident was experiencing.

During an interview a registered staff member said that no pain assessments had been completed for the resident since their admission or any other resident in the home, and that the resident's care plan did not reflect the actual pain the resident was experiencing.

The licensee has failed to ensure that when residents pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity was determined to be a level two minimum harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non compliance with this subsection of legislation. [s. 52. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 20th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALISON FALKINGHAM (518), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2017_531518_0028
Log No. / No de registre :	014745-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 18, 2017
Licensee / Titulaire de permis :	BABCOCK COMMUNITY CARE CENTRE INC. 196 Wellington Street, P.O. Box 190, Wardsville, ON, N0L-2N0
LTC Home / Foyer de SLD :	BABCOCK COMMUNITY CARE CENTRE 196 Wellington Street, P. O. Box 190, Wardsville, ON, N0L-2N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joe Babcock

To BABCOCK COMMUNITY CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall ensure that all residents exhibiting pain are assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During an interview the resident said that the pain was continuous and had been increasing over time. The resident said that the medication was not always working and that they asked for as needed (PRN) medication.

A review of the physician's current order showed that the resident was prescribed an analgesic two tablets by mouth daily and every four hours as needed and a second analgesic tablet daily in the morning.

A review of the resident's clinical record showed that registered staff had documented when the resident experienced pain, when the medication was administered and the effectiveness of the medication, however there was no documented evidence of a pain assessment completed since the resident's admission.

The inspector reviewed the resident's electronic Medication Administration Record (eMAR) which showed the resident had received the daily scheduled analgesics for pain and had received PRN analgesics for breakthrough pain on a

regular basis as requested by the resident.

Review of the home's Pain Assessment and Management Policy reviewed October 2012 stated "Each resident must have a formal pain assessment on admission and be re-assessed on re-admission, quarterly, and at least every shift. Residents experiencing pain must be treated immediately using non-pharmacological and pharmacological methods to maximize function and promote quality of life". "Nursing (RN and RPN): Conducts and documents a pain assessment, on admission, re-admission, quarterly, initiation of a pain medication or prn analgesic, resident states pain severity is a 4/10 or greater, diagnosis of painful disease, resident/family/staff/volunteers indicate pain is present, initiates a pain management flow record when a schedule pain medication does not relieve the pain or when pain remains regardless or interventions".

During an interview a registered staff member stated that "beside the three months review we don't do pain assessments with the residents" and that this resident had been having pain since their admission.

During an interview a registered staff member stated that the resident had pain and no pain assessment was completed, that the resident's care plan did not reflect the current pain the resident was experiencing and that it would be the home's expectation to have pain identified in the care plan.

During an interview two registered staff members stated that the resident had moderate to severe pain at multiple sites on their body and that the resident was using analgesics regularly. Both registered staff members also stated that there were no pain assessment completed for this resident or any resident since their admissions, that the care plan did not reflect the actual pain the resident was experiencing and that the home's expectation was that when a resident experienced pain, a pain assessment should be completed and that the care plan should reflect the resident's needs for pain relief. [s. 52. (2)]

2. During an interview the resident had stated that they experienced pain.

A review of the physician's current orders showed that the resident was prescribed an analgesic two tablets, three times a day and every four hours as needed for pain and or fever.

A review of the resident's clinical record showed that registered staff were documenting when the resident was experiencing pain, the medication administrated and the effectiveness of the medication.

There was no documented evidence of a pain assessment completed since the resident's admission and the resident's care plan made no mention of the resident experiencing pain.

During an interview two registered staff members stated the resident did not express pain often, however they felt the resident may experience pain when moved. The resident was on a regular dose of analgesics and they felt that this medication was helpful. The two registered staff members also stated the resident's care plan made no mention of the resident experiencing pain. Both staff members stated that no pain assessments were completed for the resident, and that the home's expectation was that a pain assessment should be completed.

During an interview a registered staff member stated that the resident was experiencing pain and was receiving analgesics regularly. The registered staff member said that no pain assessment was completed for that resident or any resident since admission and that there was no care plan for the resident's pain. The staff member also stated that the home's expectation was that when a resident experienced pain, a pain assessment should be completed and care planned. [s. 52. (2)]

3. During an interview the resident told the inspector that they experienced pain. The resident shared that the pain never goes away and it was increasing with time.

A review of the physician's current orders showed that the resident was prescribed an analgesic two tablets, three time a day, a different analgesic, one tablet twice daily and a third analgesic two tablets daily and two tablets every six hours as required for pain.

A review of the resident's clinical record showed that registered staff were documenting when the resident was experiencing pain, the medication administrated and the effectiveness of the medication.

The inspector reviewed the resident's electronic Medication Administration

Record (eMAR) which showed the resident had received the daily scheduled analgesics for pain and had received PRN analgesics for breakthrough pain on a regular basis as requested by the resident.

A review of the resident's clinical records found no documented evidence of a pain assessment completed since the resident's admission.

During an interview a registered staff member said that the resident had a lot of pain due to a medical condition. The registered staff member stated that no pain assessment was completed for the resident even though the resident was on regular pain medication and PRNs.

During an interview two registered staff members stated that the resident had a lot of pain due to a medical condition and was taking a lot of analgesics for it. Both said that no pain assessment had been completed for the resident since their admission or for any other resident in the home, and that the resident's care plan did not reflect the actual pain the resident was experiencing.

During an interview a registered staff member said that no pain assessments had been completed for the resident since their admission or any other resident in the home, and that the resident's care plan did not reflect the actual pain the resident was experiencing.

The licensee has failed to ensure that when residents pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity was determined to be a level two minimum harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non compliance with this subsection of legislation. [s. 52. (2)]

(615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Alison Falkingham

Service Area Office / Bureau régional de services : London Service Area Office