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 prévue 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 Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 27, 2018 | 2018_729615_0046 | 009477-18, 009969-18, 010683-18, 017749-18 | Critical Incident System |

## 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

HELENE DESABRAIS (615)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 20, 21, 22, 23 and 26, 2018.**

**The following Critical Incident (CI) reports were completed within this inspection:**

**CI #2626-000005-18/Log #009969-18 related to related to prevention of abuse and neglect;**
**CI #2626-000004-18/Log #009477-18 related to infection prevention control and program;**
**CI #2626-000006-18/Log #010683-18 related to infection prevention control and program;**
**CI #2626-000007-18/Log #017749-18 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Quality Improvement Registered Nurse (QIRN), the Activation Director (AD), two Registered Nurses (RNs) and one Registered Practical Nurse (RPN).**

**During the course of the inspection, the inspector observed staff and resident interactions, reviewed residents' clinical records, investigative notes and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date, the home submitted CI #2626-000005-18/Log #009969-18 to the Ministry of Health and Long Term Care (MOHLTC) related to resident to resident alleged physical abuse.

The Ontario Regulation 79/10 defines "physical abuse" as (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique").

A review of the home's policy "Prevention of Abuse" effective date April 2017, stated in part "Duty to Report Abuse. A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that

resulted in harm or a risk of harm to the
resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.
2007, c. 8, ss. 24 (1), 195 (2)".

A review of the CI stated in part that on a specific date an unwitnessed altercation occurred between two residents that resulted in injuries to one resident. At the time of the incident, a Registered Nurse (RN) was in charge of the home and did not report the incident immediately to the Director.

During interviews, a RN and the Activation Director, both stated that any suspicion or alleged abuse should be reported immediately to the Director.

During an interview, the Administrator stated that the home's expectation was that the RN in charge of the building should have reported the incident immediately to the Director. [s. 24. (1)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to a hospital and that results in a significant change in the resident's health condition.

On a specific date, the home submitted CI #2626-000007-18/Log #017749-18 to the MOHLTC related to a fall where a resident sustained an injury and was sent to hospital.

A review of the CI and the resident's progress notes in Point Click Care (PCC), stated in part that on a specific date, the resident was blocking a hallway's path, was asked by staff to move from the hallway and they refused to move and sat on the floor. The resident was then helped by two staff to get up the floor and moved back to their room in a wheeled chair. Later that day, the resident stated they had extreme pain in a part of their body. The registered staff observed the resident and suspected a specific injury. The resident was then sent to the hospital and was diagnosed with that specific injury.

A review of the home's policy "Resident Falls" effective date November 2017, stated in part "If the fall results in a significant change in health status for the resident then Administration/DOC must be notified immediately as a critical incident may need to be filed with the Ministry of Health. If you are unable to contact them please refer to out Critical Incident Reporting Policy in order to contact the MOH directly and give a verbal report".

During interviews, the DOC and the Quality Improvement RN, both stated that on a specific date, the resident had a significant change in status after an incident, was sent to the hospital and that the home's expectation was that the incident should have been reported to the Director within one business day. [s. 107. (3) 4.]

**Issued on this 3rd day of December, 2018**

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

**Original report signed by the inspector.**