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
Jan 31, 2019	2019_729615_0005	032461-18	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): January 23, 2019.

The following Critical Incident (CI) report was inspected during the course of this inspection:

CI #2626-000014-18/Log #032461-18 related to prevention of falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Registered Nurse, a Registered Practical nurse and a Personal Support Worker.

During the course of the inspection, the inspector(s) also observed the resident home areas and common areas, observed residents' care provisions, reviewed relevant resident clinical records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On specific date, the home submitted Critical Incident (CI) report #2626-000014-18/Log #032461-18 to the Ministry of Health and Long Term Care (MOHLTC) related to the fall of a resident with injuries.

A review of the resident's Minimum Data Set (MDS) quarterly review assessment on a specific date, stated in part that the resident needed extensive assistance with one person physical assist with Activity of Daily Living (ADL).

A review of the resident's fall risk assessment on a specific date stated in part that the resident was at high risk of falls.

A review of the resident's care plan prior to the incident stated in part that the resident needed one person constant supervision and physical assist ADLs.

A review of the resident's progress notes in Point Click Care (PCC) stated in part that on specific date the resident was found in their room bleeding from a part of their body and showing signs of pain. The resident was unable to communicate due to cognitive impairment related to a disease process.

A review of the home's CI stated in part that a Personal Support Worker (PSW) reported to the DOC that they left the resident to help another resident that was also a high risk of falls, then the resident walked unassisted and fell.

A review of the other resident's fall risk assessment on a specific date stated in part that the resident was at high risk for falls.

A review of that resident's care plan prior to the incident stated in part that the resident needed two staff for transfers with constant supervision and two person total assistance for the entire toileting process.

During interviews, two registered staff and a PSW stated that both residents should not have been left alone and needed one to two person assist for ADLs. When asked by the inspector if the fall could have been prevented, a registered staff answered yes. The two registered staff and a PSW stated that the home's expectation was that staff followed the residents' care plan.

During an interview, the DOC stated that both residents were left alone and that the

home's expectation was that care plans should be followed by staff.

The licensee has failed to ensure that the care set out in the plan of care was provided to the two residents as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, that the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of a resident's progress notes in PCC stated in part that on a specific date the resident was found on the floor of their bedroom with some soreness. The writer of the progress notes added that the resident was inspected back and bottom and vitals signs were taken.

A review of the home's policy "Falls Prevention and Management" effective date November 2017 stated in part "Post Fall Management: The interdisciplinary team will: Assess resident's level of consciousness and any potential injury associated with the fall. Complete Risk Management report and detailed progress notes".

During interviews, a registered staff and a PSW stated that when a resident sustained a fall that they should be assessed for injuries.

During an interview, the DOC and a registered staff stated that the resident was not assessed with a clinically appropriate assessment instrument that was specifically designed for falls and no Risk Management was completed for that fall.

The licensee has failed to ensure that when the resident has fallen, that the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

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 when a resident has fallen, that the resident is assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.