Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 25, 2020	2020_790730_0011	010070-20	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

CHRISTINA LEGOUFFE (730)

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): June 19, 22, 23, and 24, 2020 as an offsite inspection.

The purpose of this inspection was to inspect the following intakes:
-Critical Incident (CI) 2626-000006/ Log #010070-20 related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Quality Improvement Manager (QIM), and a Registered Practical Nurse (RPN).

The inspector also reviewed clinical records and specific policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care provided clear direction to staff who provide direct care to the resident.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC), on a specified date, related to a fall for resident #001, which resulted in a transfer to hospital and a specified injury.

A review of a specified assessment for resident #001, stated that the resident had a specified ambulatory status and required an identified intervention related to transferring.

A review of the staff communication book at the home, showed an entry, on a specified date, which stated that resident #001 now required an identified intervention for transfers and had a specified ambulatory status.

A review of the progress notes in Point Click Care (PCC), for resident #001, included a note with a specified date, which stated that the resident was being transferred back to the home and that they had a specified ambulatory status.

A review of resident #001's plan of care in PCC, on a specified date showed a focus related to transferring. Interventions for this focus were not consistent with the intervention identified by the specified assessment, note in the communication book, or progress notes.

During an interview, Registered Practical Nurse (RPN) #100 said that staff check a resident's care plan or Kardex to see what care they required. They said that all staff were responsible to keep a resident's care plan up to date. They said that resident #001 required a specified intervention related to transferring and had a specified ambulatory status, which was consistent with what was documented in specified assessment, staff communication book, and progress notes.

During an interview, Director of Care (DOC) #101 said that resident #001's plan of care had not been updated as per the home's expectation. They said that the resident's plan of care related to transferring should have been updated when the resident returned from hospital, on a specified date.

During an interview, Quality Improvement Manager (QIM) #103 said that staff had been made aware of resident #001's change in transfer status through an entry in the staff communication book prior to the resident returning from hospital, but expected that this would have also been updated in the resident's plan of care by registered staff.

B) Resident #002 was identified by Administrator #100 as a resident who had recently had a change in their transfer status.

A review of the progress notes in PCC included a "Fall Note" on a specified date, which stated that resident #002 had a fall and required a a specified intervention related to transferring. A "Health Status" note on a specified date, stated that the resident's spouse felt that the resident needed a specified intervention related to transferring. The note also stated that there was a communication note provided to staff, which informed them that the resident required a specified intervention related to transferring and the sign was changed above their bed.

A review of the staff communication book showed an entry, on a specified date, which stated that resident #002 now required a specified intervention related to transferring.

A review of the plan of care for resident #002 included a focus related to transferring. The plan of care was not updated to reflect the changes made to the resident's interventions related to transferring until a specified number of days after the intervention was noted in the progress notes and staff communication book.

During an interview Quality Improvement Manager #103, stated that there had been some minor adjustments to resident #002's plan of care related to transferring recently, but the last major change was on an earlier specified date. They said that the resident's care needs related to transferring changed on a specified date, but that this was not updated in their plan of care until a later date. They said that there was a note written in the staff communication book, but they would have expected registered staff to have updated the plan of care as soon as the change was made.

The licensee has failed to ensure that clear direction was provided to staff who provided care to residents #001 and #002 related to transferring. [s. 6. (1) (c)]

Issued on this 26th day of June, 2020

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

Original report signed by the inspector.