Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: December 19, 2024
Inspection Number: 2024-1135-0005
Inspection Type: Critical Incident
Licensee: Babcock Community Care Centre Inc.
Long Term Care Home and City: Babcock Community Care Centre, Wardsville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 2, 3, 4, 2024

The following intake(s) were inspected:

- Intake: #00132300 - 2626-000018-24 ARI - related to Infection Prevention and Control.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Hand Hygiene

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that hand hygiene protocol issued by the Director was completed with residents prior to a meal service.

Summary and Rationale:
As per IPAC Standard 10.4 (h) issued by the Director, it was the expectation that "support [was to be given] for residents to perform hand hygiene prior to [having] received meals."

During an observation of a lunchtime meal service, three residents were noted to have seated themselves and to have begun eating their meals without having completed hand hygiene or having been offered assistance to complete hand hygiene by staff. When questioned, they all explained that they did not complete hand hygiene in their rooms or on their way to the dining room, nor did staff offer to assist them with hand hygiene.

In an interview completed with the IPAC Lead, it was explained that it was the home's expectation that all residents were to have completed hand hygiene or offered a hand hygiene opportunity prior to have taken their meals. They acknowledged that the hand hygiene policy was not followed with residents.

There was risk of the spread of infection when residents were not encouraged to completed hand hygiene prior to taking their meals.

Sources: lunchtime observation, interview with IPAC Lead and IPAC Standards for Long-Term Care Homes.