Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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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
Dec 22, 2021	2021_974670_0031	019639-21	Proactive Compliance 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

DEBRA CHURCHER (670), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): December 9, 10, 13, 14, 15, 16 and 17, 2021.

The purpose of this inspection was to inspect Log #019639-21 to conduct a Proactive Compliance Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Food Service Supervisor, one Pharmacist, one Social Worker, two Housekeepers, four Registered Nurses, two Registered Practical Nurses, two Personal Support Workers, the Family Council President and residents.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance of the home, observed the provision of care, observed staff to resident interactions, observed medication administration, observed a dining service, observed infection prevention and control practices, monitored door and window safety, completed relevant interviews, completed relevant resident record reviews, completed relevant internal documentation reviews and completed relevant policy and procedure reviews.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

5 WN(s)
5 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plans of care were based on an assessment of resident #007, resident #008, and resident #011 and the communication needs of those three residents with a verbal, auditory and/or cognitive alteration.

The current care plans for resident #007, resident #008 and resident #011 identified the residents as having the inability to perform specific functions despite the Minimum Data Set (MDS) assessment indicating that all three residents could perform the specific functions.

Registered Practical Nurse (RPN) #109 stated that the MDS assessment for each resident was used to create the care plan focus. RPN #109 verified that the current MDS assessment for each resident was an accurate representation of their abilities. The Director of Care (DOC) #101 and RPN #109 shared that all three residents had the ability to perform the specific functions. Both RPN #109 and DOC #101 stated that repetitive standard statements were used to create the plan of care, and the plan of care was not edited to be individualized to the residents needs when the residents' were reassessed quarterly using the MDS as the assessment tool.

Resident #007, #008 and resident #011 were observed throughout the course of the inspection performing specific functions.

The current care plan for resident #007, #008 and #011 did not reflect an accurate assessment of the residents' abilities and needs.

Sources: residents' clinical records, residents' observations and interviews, and staff interviews with RPN #109 and DOC #101. [s. 6. (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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008’s medication was administered on a specific date in accordance with the directions for use specified by the prescriber.

Resident #008 had an order for a medication to be administered at a specific time. Registered Practical Nurse (RPN) #106 wrote a progress note on a specific date that stated resident #008 did not receive their medication at a specific time.

The Babcock Community Care Centre Medication Admin Audit Report in Point Click Care documented that Registered Nurse (RN) #110 signed the order as administered on a specific date at a specific time. RN #110 verified they signed for the medication but did not administer the medication to resident #008.

The failure to administer the medication as per the orders placed resident #008 at risk.

Sources: staff interviews with RN #110 and RPN #106, the Babcock Community Care Centre Medication Admin Audit Report, electronic Medication Administration Records, resident #008’s progress notes and physician orders. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider.

Resident #008 had an order for a medication to be administered at a specific time. Registered Practical Nurse (RPN) #106 wrote a progress note on a specific date that stated resident #008 did not receive their medication at a specific time.

RPN #106 and RN #110 stated the omission of the ordered medication was a medication incident and a report should have been documented. RPN #106 stated they informed resident #008 but no one else. Director of Care #101 verified the medication incident was not reported to them.

All medication incidents involving a resident require documentation and follow up. The absence of the documented record inhibits the home’s ability to reduce and prevent similar medication incidents from reoccurring.

Sources: resident #008’s clinical record; and interviews with RPN #106, RN #110 and DOC #101. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a drug that was to be destroyed was not a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing.

Ontario Regulation 79/10 r. 136 (6) states, “For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.”

The Medication Preparation room was observed on December 10, 2021, with RPN #106 RN #108 and RN #115 present. RN #108 stated there were medications for destruction locked behind a cupboard door under the counter and shared there was a key for the cupboard that stayed in the med room for all registered nursing staff to access and dispose of expired and discontinued medications in the cardboard box. RN #108 unlocked and opened the cupboard, picked up intact strip medication packages off the floor of the cupboard and placed them in the cardboard box. RN #115 said they did not need to unlock the cupboard because they usually just slipped the medication pack through the opening at the top of the cupboard doors.

On December 13, 2021, the Medication Preparation room was observed with RPN #116 present. There was a medication card with intact tablets of Melatonin, one box of Haloperidol Injection and one box of Scopolamine Hydrobromide Injection. There were also multiple medication strip packages of intact medications.

Director of Care #101 stated the Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised November 2020 was the policy used by the home for the destruction and disposal of medications.

The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised November 2020 documented, “All medications identified for destruction must be destroyed safely and securely.” “Remove medications identified for disposal/destruction from the packaging and place in container dedicated for disposal of surplus medications (i.e. Stericycle containers)."

The safety and security of the drug supply was compromised when expired or discontinued drugs were not altered or denatured to such an extent that consumption was rendered impossible or improbable.

Sources: Medical Pharmacies Drug Destruction and Disposal Policy 5-4, observations of the Medication Preparation room, and interviews with the DOC and registered nursing staff. [s. 136. (3) (b)]

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 drugs must be destroyed by a team acting together and composed of, in every other case, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program related to the use of expired alcohol-based hand sanitizer.

Inspectors observed two portable containers of Aloe Care Foaming Hand Sanitizer in the administrative office area at the main entrance of the home with expiry dates of May 2019 and July 2020. A third container was observed in the Director of Care's office with an expiry date of April 2021. All three containers were approximately half full.

The office area was used by the Administrative Assistant, the DOC and the Social Worker during the course of the inspection and other staff visited this office area for various reasons. Social Worker #105 was sitting at the desk and verified that the Aloe Care Foaming Hand Sanitizer with an expiry date of May 2019 was used. DOC #101 stated the housekeeping staff were responsible for ensuring the alcohol-based hand sanitizer was not expired and the office area was missed as part of that audit.

The home put staff and others at risk by providing expired hand sanitizer as part of the infection prevention and control program. The Aloe Care had expired one to two years ago and should have been removed from use and replaced.

Sources: observations and staff interviews with the Social Worker and DOC. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 23rd day of December, 2021

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

Original report signed by the inspector.