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 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 sions de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 9, 2016 | 2016_283544_0002 | 000489-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

BINGHAM MEMORIAL HOSPITAL
507 8th Avenue PO Box 70 Matheson ON P0K 1N0

### Long-Term Care Home/Foyer de soins de longue durée

ROSEDALE CENTRE
507- 8th Avenue P.O. Box 70 Matheson ON P0K 1N0

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

FRANCA MCMILLAN (544), ALAIN PLANTE (620)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): January 25, 26, 27, 28 , 2016, and February 1, 2, 2016.**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Chief Financial Officer (CFO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Personal Support Workers (PSWs), Maintenance staff, Residents and Families.**

**During the course of the inspection, the Inspectors also toured the home daily, directly observed the delivery of care and services to the residents, staff to resident interactions, dining, snack and meal service delivery, medication administration, reviewed resident health care records, resident care plans and the home's policies, procedures and programs pertinent to this inspection.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Reporting and Complaints**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**
**Trust Accounts**

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

**7 WN(s)**
**5 VPC(s)**
**1 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 | Legendé<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. |

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that the home was maintained in a good state of repair.

Inspectors toured the home and identified that all the doors and door frames for all the resident rooms and the common areas were scuffed and the paint was peeling off the doors and door frames.
The wall paper on the walls and the ceilings, in several of the resident rooms, was peeling off. Several bathroom vanities required to be repaired.
The floor, entering the shower, was uneven and the caulking was missing around the edge where the floor and the shower meet.

The Inspectors interviewed the Director of Care and Housekeeper # 102 who told the Inspector that the hallways, doors and doorways had not been painted in several years. Housekeeper # 102 told the Inspector that they had not been painted in the last ten years. [s. 15. (2) (c)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Resident # 002 was identified, through Stage 1 activities of an RQI that was conducted in the home, as having exhibited increased signs and symptoms of pain. According to the progress notes, resident # 002 frequently exhibited signs of pain.

A review of resident # 002's health care record, by the Inspector, identified that a pain assessment conducted identified that resident # 002 was exhibiting pain. A second pain assessment, conducted a few months later, identified resident # 002 was exhibiting an increase in their pain.

Inspector reviewed resident # 002's Medication Administration Record (MAR) and identified that resident # 002 received pain medication on a daily basis, for several weeks, to manage their pain.

The Inspector reviewed resident # 002's plan of care and identified that there were no focus, goals or interventions identified in the plan of care to manage resident # 002's pain.

Inspector interviewed the Director of Care (DOC) and RPN # 103 who confirmed that resident # 002's plan of care was not reviewed and revised to address their pain and when resident # 002's care needs changed and should have been. [s. 6. (10) (b)]

2. The licensee failed to ensure that the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when, the

resident's care needs changed or care set out in the plan was no longer necessary.

Resident # 006 was identified as exhibiting signs and symptoms of increased pain, through Stage 1 activities of an RQI that was conducted in the home. Resident # 006 had sustained an injury.

The Inspector reviewed resident # 006's health care record which identified that a pain assessment was conducted and resident # 006 exhibited no signs and symptoms of pain. A second pain assessment that was conducted a few months later, identified that resident # 006 exhibited signs and symptoms of pain.

Inspector reviewed resident # 006's Medication Administration Record (MAR) and identified that resident # 006 received pain medication daily to manage their pain.

The Inspector reviewed resident # 006's plan of care and identified that there were no focus, goals or interventions identified in the plan of care to manage resident # 006's pain.

Inspector observed resident # 006 and identified that resident # 006 exhibited signs and symptoms of pain.

Inspector interviewed the Director of Care (DOC) and RPN # 103 who confirmed that resident # 006's plan of care was not reviewed and revised to address their pain and when resident # 006's care needs changed and should have been. [s. 6. (10) (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 the written plan of care for residents # 002 and # 006 are reviewed and revised at least every six months and at any other time when resident # 002's and resident # 006's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system, the licensee was required to have, was complied with.

Inspector # 620 observed medication administration conducted by RPN # 108. RPN # 108 was observed to ask for the assistance of RPN # 103 to confirm the correct dosage of some medications. RPN #103 co-signed the clinical record confirming the correct dosages.

A record review confirmed that RPN # 108 had recorded that they administered medications to residents #006, # 010, and # 011. The Medication Administration Record (MAR) for residents # 006, # 010, and # 011 directed staff to refer to a form to confirm the administration of the these medications.

RPN # 108, who was interviewed by Inspector # 620, stated that they documented, "yes" to the administration of these medications. An hour after they documented the administration these medications, RPN # 108 confirmed that residents # 006, # 010, and # 011 had not yet received their medications.

A review of the home's policy, Medication Administration Record, 8-1, revealed that staff were expected to, "document on the Medication Administration Record (MAR), in the proper space for each medication administered or document by code if the medication was not given." The policy further advised staff to, "Chart all medications administered by signing your initials in the appropriate box corresponding to correct medication, date, and time on the MAR.

Inspector # 620 interviewed the DOC who confirmed that it was the home's expectation that the staff follow the home's medication policy and staff were only to document the administration of the medication after the medication had been administered. The DOC confirmed that RPN # 108 documented the administration of a medication that had not yet been administered and should not have. [s. 8. (1) (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 the Medication Administration policy is complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

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

**s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,**
**(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).**
**(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a Registered Dietitian (RD), who is a member of the staff of the home, completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition.

A review of resident # 001's health care record, by the Inspector, revealed that resident # 001 had a documented significant weight loss. Resident # 001's health care record also identified that following a significant weight change, no assessment of the resident's nutritional status occurred until a few months later. The annual assessment stated that resident # 001 had experienced, "a significant weight loss this quarter."

Inspector # 620 reviewed the home's policy titled, "Weight and Height Audit and Weight Change Protocol." The policy stated that unplanned weight changes of greater than 5 per cent over one month, 7.5 per cent over three months, or 10 per cent over six months were to be referred to the RD. The policy stated that the RD was to review significant weight changes for all residents of the home at least monthly. The policy further noted that the RD was expected to conduct a thorough assessment of each resident referred,

and investigate possible nutrition factors responsible for the significant weight changes.

Inspector # 620 interviewed the RD who told the Inspector that they were not aware of resident # 001's significant weight change. They also stated that they had not received a multidisciplinary referral form and should have to conduct an assessment. The RD stated that it was the home's expectation that significant weight changes were to be assessed. With respect to resident #001's significant weight change, an assessment did not occur and should have.

Inspector # 620 interviewed the DOC who confirmed that it was the home's expectation that significant weight changes were to be assessed by the RD. The DOC also stated that significant weight changes were to be referred to the RD by the registered staff. The DOC confirmed that a referral for resident # 001 had not been sent to the RD by the registered staff following a significant weight change, therefore, no assessment of the resident's nutritional status occurred and should have. [s. 26. (4) (a),s. 26. (4) (b)]

2. The licensee failed to ensure that a Registered Dietitian (RD), who is a member of the staff of the home, completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition.

A review of resident # 005's health care record, by the Inspector, revealed that resident # 005 had a documented significant weight loss.

Inspector reviewed the home's policy titled, "Weight and Height Audit and Weight Change Protocol." The policy stated that unplanned weight changes of greater than 5 per cent over one month, 7.5 per cent over three months, or 10 per cent over six months were to be referred ton the RD. The policy stated that the RD was to review significant weight changes for all residents of the home at least monthly. The policy further noted that the RD was expected to conduct a thorough assessment of each resident referred, and investigate possible nutrition factors responsible for the weight changes.

A review of resident # 005's health care record identified that following a significant weight change, no assessment of the resident's nutritional status occurred until several weeks later. The annual assessment stated that resident # 005 had experienced, "a significant weight loss."

Inspector # 620 interviewed the RD who told the Inspector that they were not aware of the significant weight change that had occurred in regards to resident # 005. They also

stated that they had not received a multidisciplinary referral form and should have.

The RD stated that it was the home's expectation that significant weight changes were to be assessed. With respect to resident #005's significant weight change, an assessment did not occur and should have.

Inspector # 620 interviewed the DOC who confirmed that it was the home's expectation that significant weight changes were to be assessed by the RD. The DOC also stated that significant weight changes were to be referred to the RD by registered staff. The DOC confirmed that a referral to the RD had not been sent by the registered staff following a significant weight change, therefore, no assessment of the resident # 005's nutritional status had occurred and should have. [s. 26. (4) (a),s. 26. (4) (b)]

3. The licensee failed to ensure that a Registered Dietitian (RD), who is a member of the staff of the home, completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition.

A review of resident # 006's health care record, by the Inspector, revealed that resident # 006 had a documented significant weight loss. The health care record also revealed that following a significant weight change, no assessment of the resident's nutritional status occurred until several weeks later. The annual assessment stated that resident #006 had experienced, "a significant weight loss."

Inspector # 620 reviewed the home's policy titled, "Weight and Height Audit and Weight Change Protocol." The policy stated that unplanned weight changes of greater than 5 per cent over one month, 7.5 per cent over three months, or 10 per cent over six months were to be referred to the RD.
The policy stated that the RD was to review significant weight changes for all residents of the home at least monthly. The policy further noted that the RD was expected to conduct a thorough assessment of each resident referred, and investigate possible nutrition factors responsible for the weight changes.

Inspector #620 interviewed the RD who told the Inspector that they were not aware of the significant weight change that had occurred in regards to resident #006. They also stated that they had not received a multidisciplinary referral form and should have. The RD told the Inspector that it was the home's expectation that significant weight changes were to be assessed and that an assessment of resident # 006's nutritional status did not occur and should have.

Inspector # 620 interviewed the DOC who confirmed that it was the home's expectation that significant weight changes were to be assessed by the RD. The DOC also stated that significant weight changes were to be referred to the RD by registered staff. The DOC confirmed that resident # 006 was not referred to the RD by the registered staff following a significant weight change, therefore, no assessment of the resident # 006's nutritional status occurred and should have. [s. 26. (4) (a),s. 26. (4) (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 a Registered Dietitian, who is a member of the staff of the home, completes a nutritional assessment for resident #001, # 005 and # 006 and all residents whenever there was a significant change in the resident's health condition, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

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

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were stored in an area or a medication cart

that was used exclusively for drugs and drug-related supplies and that was secure and locked.

The Inspector observed a medication cart unlocked and unattended in a common area of the home.

Inspector # 620 interviewed RPN # 108 regarding the unlocked medication cart. RPN # 108 stated that it was the expectation of the home that the unattended medication cart was to be locked when unattended. RPN # 108 confirmed that the medication cart had not been locked and should have been.

Inspector # 620 interviewed the DOC who confirmed that it was the home’s expectation that the medication cart be locked at all times when not in use. The DOC stated that this had not occurred, and should have. [s. 129. (1) (a)]

2. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector # 620 conducted an inspection of the home’s medication storage area. Within the medication storage room, the Inspector observed an emergency stock storage container sitting on the counter. The storage container was made of plastic and was secured by a single locked padlock.

A record review of the emergency stock monitoring form revealed that the container held controlled substances. This was further confirmed through Inspector # 620's observation.

Inspector # 620 reviewed the home’s policy regarding the storage of controlled substances. The policy stated that all controlled substances were to be double locked in a designated locked medication room.

Inspector # 620 inquired about the contents of the medication stored within the emergency stock storage container. RPN # 103 and RPN # 108 both confirmed that the emergency stock storage container contained control substances. They further confirmed that it was standard practice to store the container on the counter within the medication room.

Inspector # 620 interviewed the DOC who confirmed that the controlled substances, held in the home's emergency stock storage container, were not double locked. The DOC also confirmed that it was the home's expectation that controlled substances were to be double locked within the designated locked medication room and that this had not occurred and should have. [s. 129. (1) (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 are stored in an area or a medication cart that is secure and locked at all times, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts**

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

**s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).**

**s. 241. (7) The licensee shall,**
**(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).**

**Findings/Faits saillants :**

1. The licensee failed to establish and maintain one non-interest bearing trust account, at a financial institution, for depositing money entrusted to the licensee's care on behalf of a resident.

In a family interview, resident # 008's family member told the Inspector that they did not recall ever receiving a statement of account for resident # 008's monies that were kept in trust, by the home, for incidentals that were required to be purchased.

Inspector reviewed the Rosedale Centre Purchase of Services Agreement and identified that there was no documentation to support that the home had established and maintained a trust account for the residents.

Inspector interviewed the Chief Financial Officer (CFO), who told the Inspector that the home did not establish or maintain at least one non-interest bearing trust account at a financial institution in which the licensee was to deposit all money entrusted to the licensee's care on behalf of the residents and should have. They also confirmed that the home did not have any written policies or procedures for the management of resident trust accounts and the residents' petty cash trust money. [s. 241. (1)]

2. The licensee failed to provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident including deposits and withdrawals and the balance of the resident's funds as of the date of the statement.

In a resident family interview, resident # 008's family member told the Inspector that the family was not receiving quarterly itemized statements for resident # 008's petty cash fund. The family member stated, to the Inspector, that they received a notice and ledger balance when the funds were at the minimum amount.

Inspector interviewed the Accounts Payable staff member # 104 and the DOC who both told the Inspector that they sent out a statement of account to the resident and/or their families, which included their balance, whenever the resident's trust fund was at the minimum amount. The DOC and the Accounts Payable staff member # 104 confirmed that quarterly itemized statements were not sent out to the residents or their Substitute Decision Maker/Power of Attorney and should have been sent out. [s. 241. (7) (f)]

***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 the licensee establishes and maintains one non-interest bearing trust account, at a financial institution, for depositing money entrusted to the licensee's care, on behalf of a resident, and provide the resident a quarterly itemized written statement, respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement, to be implemented voluntarily.***

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**WN #7: 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 failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector reviewed resident # 006's health care record and noted in the progress notes that resident # 006 had a fall. The progress notes also indicated that the resident sustained an injury that required care.

Resident # 006's care plan indicated that resident # 006 had mobility issues and was at risk for falls.

Inspector reviewed resident # 006's fall assessments and incident notes and identified that the resident had a fall and there was no documentation to support that a post fall assessment was conducted or completed.

Inspector interviewed RPN # 107, who reviewed resident # 006's health care record with the Inspector. RPN # 107 confirmed that a post fall assessment was not conducted or completed when resident # 006 fell.

Inspector #620 interviewed the DOC who confirmed that a post-fall assessment had not been completed for resident #006. The DOC stated that it was the home's expectation that post fall assessments were to be conducted for all residents who had fallen and that with respect to resident #006, this had not occurred, and should have. [s. 49. (2)]

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**Issued on this 11th day of March, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de sions de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | FRANCA MCMILLAN (544), ALAIN PLANTE (620) |
| **Inspection No. / No de l'inspection :** | 2016_283544_0002 |
| **Log No. / Registre no:** | 000489-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Mar 9, 2016 |
| **Licensee / Titulaire de permis :** | BINGHAM MEMORIAL HOSPITAL<br>507 8th Avenue, PO Box 70, Matheson, ON, P0K-1N0 |
| **LTC Home / Foyer de SLD :** | ROSEDALE CENTRE<br>507- 8th Avenue, P.O. Box 70, Matheson, ON, P0K-1N0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Diane Stringer |

To BINGHAM MEMORIAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

**Order / Ordre :**

The licensee shall:

a) complete a maintenance audit of the entire home and act on the results of the audit to ensure that the home's interior is maintained in a good state of repair;

b) ensure that a record of remedial maintenance is maintained and that the record includes the initiation and completion of all remedial maintenance work.

**Grounds / Motifs :**

1. The licensee failed to ensure that the home was maintained in a good state of repair.

Inspectors toured the home and identified that all the doors and door frames for all the resident rooms and the common areas were scuffed and the paint was peeling off the doors and door frames.
The wall paper on the walls and the ceilings, in several of the resident rooms, was peeling off. Several bathroom vanities required to be repaired.
The floor, entering the shower, was uneven and the caulking was missing around the edge where the floor and the shower meet.

The Inspectors interviewed the Director of Care and Housekeeper # 102 who told the Inspector that the hallways, doors and doorways had not been painted in several years. Housekeeper # 102 told the Inspector that they had not been painted in the last ten years.

The scope of this issue is widespread and there has been previous non-compliance where a written notification was issued in 2014. The severity is determined to be minimal harm or potential for actual harm. This impacts negatively on the health, safety and well-being of the residents. (544)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 02, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 9th day of March, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Franca McMillan

**Service Area Office /**
**Bureau régional de services :** Sudbury Service Area Office