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 soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2017	2017_557575_0009	005861-17	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

LINDSAY DYRDA (575), RYAN GOODMURPHY (638)

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): April 3-7, 2017.

The following additional intakes were inspected during this Resident Quality Inspection:

One follow-up related to Compliance Order #001 issued during inspection #2016_283544_0002 related to maintenance in the home; and

One critical incident the home submitted to the Director regarding allegations of improper care of a resident that resulted in harm to the resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Infection Prevention and Control Program Leader, Maintenance Manager, Maintenance staff, Activity Director, Registered Dietitian, Family and Residents' Council members, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, family members, and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

7 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_283544_0002	638

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	Legendé 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Falls Prevention and Management program included a written description that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

During stage one of the inspection, it was identified during an interview with RPN #105 that resident #001 had sustained a fall within the last 30 days.

Inspector #638 reviewed resident #001's progress notes which identified that on a specific day in March 2017, RPN #109 documented that resident #001 had sustained an unwitnessed fall.

Inspector #575 reviewed the home's policy titled "Fall Prevention and Management

Program" last reviewed June 23, 2016, which indicated that registered staff were to initiate a Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that had resulted in a possible head injury or if the resident was on anticoagulant therapy. The policy indicated that the HIR was outlined under an appendix, however, the appendix number was blank and not included in the policy.

In an interview with Inspector #638, RPN #105 stated that any unwitnessed fall would require the initiation of a HIR in order to monitor and ensure resident status. The Inspector reviewed resident #001’s documentation with RPN #105 who stated that a HIR was not initiated after their unwitnessed fall on March 12, 2017.

During an interview with Inspector #575, the Director of Care (DOC) indicated that they were aware the HIR was not included in the home's policy and that they were in the process of implementing a new HIR which would be added to the current policy. [s. 30. (1) 1.]

2. During stage one of the inspection, it was identified during a staff interview that resident #007 had sustained a fall within the last 30 days.

Inspector #575 reviewed resident #007's health care record and noted that on a specific day in March 2017, resident #007 was found on the floor in a certain area. The post fall assessment investigation checklist stated that this fall was unwitnessed.

The Inspector reviewed resident #007's health care record with RPN #105 who confirmed that after resident #007's unwitnessed fall, a HIR was not completed. [s. 30. (1) 1.]

3. During stage one of the inspection, it was identified during a staff interview that resident #004 had sustained an unwitnessed fall within the last 30 days.

Inspector #575 reviewed resident #004's health care record and noted that on a specific day in March 2017, resident #004 was found on the floor in a certain area. The post fall assessment investigation checklist stated that this fall was unwitnessed.

The Inspector reviewed resident #007's health care record with RPN #105 who confirmed that after resident #004's fall, a HIR was not completed. [s. 30. (1) 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 ensuring that the Falls Prevention and Management Program includes a written description of the program including relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Assistant to the Residents' Council, they indicated that the Residents' Council's advice was not sought in the development or implementation of the satisfaction survey.

Inspector #575 reviewed the Residents' Council meeting minutes for 2016. The Inspector noted that there was no discussion regarding the development or implementation of the survey, however, the results from the 2015 survey were shared during a meeting in August 2016.

During an interview with the DOC, they indicated that the survey was changed in 2016 without consultation from the Residents' Council. [s. 85. (3)]

2. The licensee has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with a member of the Family Council, they indicated to Inspector #575 that the Family Council's advice was not sought in the development or implementation of the satisfaction survey, or in acting on its results.

During an interview with the DOC, they indicated that the survey was changed in 2016 without consultation from the Family Council. [s. 85. (3)]

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 ensuring that they seek the advice of the Residents' and Family Councils in developing and carrying out the satisfaction survey and in acting on its results, to be implemented voluntarily.

WN #3: 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.

Inspector #638 observed RPN #102 complete a medication pass on a specific date during the inspection. The Inspector observed RPN #102 administer medications to residents #001, #004, #007, #009, #010, #011 and #012 without performing hand hygiene before or after interactions with any of the seven residents listed.

In an interview with Inspector #638, RPN #102 stated that they should have performed hand hygiene after each interaction with a resident. RPN #102 stated that they forgot to implement hand hygiene practices for each of these circumstances during the medication pass.

The home's policy titled "Hand Hygiene" last reviewed May 2011, indicated that staff were expected to perform hand hygiene before initial resident contact in order to protect resident's from harmful germs and after resident contact in order to protect the environment from harmful resident germs.

In an interview with Inspector #638, the DOC stated that it was the home's practice that all staff perform hand hygiene before and after interactions with residents. [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 ensuring that staff participate in the implementation of the infection prevention and control program, specifically, hand hygiene, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in May 2016, regarding an allegation of improper/incompetent treatment of a resident that resulted in harm to the resident. The CI report described an incident that occurred the previous day, whereby, resident #008 sustained an injury while staff were providing care.

During an interview with the DOC, they indicated that they started the investigation immediately and that the incident occurred the day before it was reported to the Director. They confirmed that the incident should have been reported immediately. [s. 24. (1)]

WN #5: 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 the resident has fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During stage one of the inspection, it was identified during a staff interview that resident #007 had a fall within the last 30 days.

During an interview with RPN #105, they indicated to Inspector #575 that after a resident has a fall, staff are to complete a progress note in Point Click Care (PCC), a post fall assessment investigation checklist and the Morse fall risk scale.

Inspector #575 reviewed resident #007's health care record and noted that after resident #007 sustained a fall on a specific date in March 2017, a post fall assessment investigation checklist was completed, however, the Morse fall risk scale was not completed.

Inspector #575 reviewed the home's policy titled "Fall Prevention and Management Program" last reviewed June 23, 2016, which indicated that after every fall the post fall assessment investigation checklist and a Morse fall risk assessment was to be completed.

During an interview, RPN #105 confirmed that after resident #007's fall, the Morse fall risk scale was not completed. [s. 49. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

During stage one of the inspection it was identified through resident #006's most recent Minimum Data Set (MDS) assessment that they had a weight loss of 5% or more in the last 30 days or 10% or more in the last 6 months.

At the time of the inspection, the most recent MDS assessment was completed on a specific date in December 2016. Inspector #575 reviewed resident #006's weights from June to December 2016, and noted the resident had experienced fluctuating weight losses and gains during this six month period.

During an interview with RPN #105, they indicated to Inspector #575 that every week, registered staff will review all weights inputted for the previous week and if there was a significant change, they would send the Registered Dietitian (RD) an email or complete a referral form.

Inspector #575 reviewed resident #006's plan of care and on a specific date in October

2016, the RD received a referral regarding resident #006's weight loss. The Inspector noted that from June to September 2016, the resident lost 9% of body weight over this three month period. On the same day in October 2016, a progress noted indicated that the RD was adding a specific nutrition intervention. A review of the resident's care plan revealed that the specific nutrition intervention was added to the resident's care plan on the same day and was written in the physician's orders by the RD. Inspector #575 noted that the specific nutrition intervention was not entered into the Medication Administration Record (MAR) until approximately one month later.

Inspector #575 further reviewed the progress notes which indicated that on a specific day in November 2016, the RD was advised of further weight loss and that the previous nutrition intervention was not processed. The Inspector noted that from July to October 2016, the resident lost 12 % of body weight over this three month period.

During interviews with RPN #105, the RD, and the DOC, they stated that the order written on a specific day in October 2016, was missed and confirmed that the resident did not receive the specific nutrition intervention until approximately one month later. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Inspector #638 observed RPN #102 complete a medication pass on a specific day during the inspection. The Inspector observed RPN #102 remove resident #001's medications from the medication cart. The Inspector identified that some of the medications had already been removed from their packaging and placed in a medication cup prior to the medication pass.

In an interview with Inspector #638, RPN #102 stated that the medications which were already removed from their packaging were medications that resident #001 had refused during the previous medication pass completed by RPN #105. RPN #102 stated that RPN #105 reported to them that they had already prepared resident #001's medications and that they left them in the medication cart to administer at a later time. RPN #102 stated that staff have been known to prepare medications and remove them from their packaging in advance at times.

In an interview with RPN #105 they stated that they had removed the medications from their packaging during the previous medication pass on the same day. RPN #105 stated that they had intended on going back later to administer the resident's medications, however, RPN #102 had been assigned the medication duties and the medications remained in the resident's bin in the medication cart.

In a review of resident #001's progress notes, Inspector #638 identified that on the same day, RPN #105 documented that the resident had refused some of their medications and that they would attempt to administer the medications later.

The home's policy titled "The Medication Pass" 3-6 last revised February 2017, indicated that if a medication was refused after being removed from the packaging, staff would document the refusal on the MAR and prepare the medication for destruction.

In an interview with Inspector #638, the DOC stated that if a resident refused their medication staff should document the refusal of the medication and destroy the medication accordingly. The DOC then stated that when a medication was removed from its original packaging staff should not save the medication in an to attempt to administer the medications at a later time. [s. 126.]

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Issued on this 25th day of April, 2017

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

Original report signed by the inspector.