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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2021	2021_668543_0002	022588-20	Critical Incident System

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

TIFFANY BOUCHER (543)

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): January 27-28, 2021.

The following intake that was submitted to the Director was inspected during this inspection:

-one intake; related to a resident elopement.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Infection Prevention and Control (IPAC) Lead, Support Services Manager, Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Housekeeping staff.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules and policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

In accordance with Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, Long-Term Care Homes were required to implement active screening of all staff, visitors and anyone else entering the home for COVID-19, active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks.

On two separate days in January 2021, upon exiting the home at the end of their day, the Inspector’s temperature was not taken.

In an interview with the Director of Care, they verified that the screening process did not include taking the temperatures of visitors at the end of the day or visit.

Sources: Inspector observations, COVID-19 Directive #3 for Long-Term Care Homes and interviews with the Director of Care and other staff. [s. 5.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee of the home has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimeters.

Resident #001 eloped from the home by exiting through a window.

As a result of the window having the ability to open greater than 15 centimeters, resident #001 was able to exit the home.

In an interview with the Director of Care they verified that the resident was able to exit the home from a window.

Source: Critical Incident Report, Inspector observations, resident #001's record review, interviews with the Director of Care and other staff members. [s. 16.]

Issued on this 18th day of February, 2021

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

Original report signed by the inspector.