

**Ministry of Long-Term Care**

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

**North District**

159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Original Public Report

**Report Issue Date:** August 27, 2024

**Inspection Number:** 2024-1257-0001

**Inspection Type:**

Critical Incident

**Licensee:** Bingham Memorial Hospital

**Long Term Care Home and City:** Rosedale Centre, Matheson

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20 & 21, 2024

The following intake(s) were inspected:

- One intake related to the neglect of a resident.

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

Resident Care and Support Services  
Infection Prevention and Control

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

#### **Non-compliance with: FLTCA, 2021, s. 6 (4) (b)**

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in different aspects of the residents care, collaborated with each other in the assessment of the resident.

#### **Rationale and Summary:**

A review of the resident's plan of care revealed that a resident had experienced a change in health status. However, the Registered Nurse (RN) and Physician were not informed of this change until several days later. During interviews with a staff member and the director of care (DOC), it was determined that the resident was not assessed by the RN or Physician until several days later, and that the expectation is that the RN and Physician are to be notified when a resident experiences a change in health status.

The resident faced moderate risk and impact due to the homes failure to collaborate with the RN and Physician in the assessment of a resident, when the resident experienced a change in health status.

**Sources:** Resident's plan of care; and interviews with staff.