Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: April 15, 2025
Inspection Number: 2025-1257-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Bingham Memorial Hospital
Long Term Care Home and City: Rosedale Centre, Matheson

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 7-10, 2025

The following intake was inspected:

- One intake related to a Proactive Compliance Inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Pain Management

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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided as outlined.

Sources: Observations; a resident's plan of care; and interviews with staff members.

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that air temperatures were measured and documented as specified in the regulations, on multiple occasions.

Sources: The home's air temperature logs; and an interview with a registered staff member and the Plant Maintenance Manager (PMM).

WRITTEN NOTIFICATION: General Requirements for Programs (Pain Management)

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (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 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
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.

The licensee has failed to ensure that the pain management program was updated and evaluated annually.

Sources: The home's pain management program; and interviews with the Director of Care (DOC) and a registered staff member.

WRITTEN NOTIFICATION: General Requirements for Programs (Skin and Wound Management)

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements

s. 34 (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 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
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.

The licensee failed to ensure that the skin and wound management program had a written evaluation completed annually.

Sources: The home's skin and wound management program; and interviews with the DOC and a registered staff member.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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.

The licensee has failed to ensure that there was a written record of the annual review and evaluation of the nursing and personal support services staffing plan.

Sources: The home's staffing budget; and an interview with the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long Term Care (LTC) Homes issued by the Director, was implemented. Specifically, that all residents were supported to perform hand hygiene before meals.

Sources: Observations; IPAC Standard for LTC Homes, section 10.2, revised September 2023; and interviews with staff members.

WRITTEN NOTIFICATION: Quarterly Evaluation (Drugs)

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124
Quarterly evaluation
s. 124.
(1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).
(2) Where the pharmacy service provider is a corporation, the licensee shall ensure that a pharmacist from the pharmacy service provider participates in the quarterly

evaluation. O. Reg. 246/22, s. 124 (2).
(3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk;
(b) reviewing reports of any medication incidents, any incidents of severe hypoglycemia and unresponsive hypoglycemia, the use of glucagon and adverse drug reactions referred to in subsections 147 (2) and (3), the factors that contributed to the incident, use of glucagon or drug reaction and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 39 of the Act; and
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 246/22, s. 124 (3); O. Reg. 66/23, s. 25 (1).
(3.1) For the purposes of clause (3) (a), and without limiting the generality of this section, the review of drug utilization trends and drug utilization patterns in the home must include trends and patterns associated with the use of glucagon in the home. O. Reg. 66/23, s. 25 (2).
(4) The licensee shall ensure that the changes identified in the quarterly evaluation are implemented. O. Reg. 246/22, s. 124 (4).
(5) The licensee shall ensure that a written record is kept of the results of the quarterly evaluation and of any changes that were implemented. O. Reg. 246/22, s. 124 (5).

The licensee has failed to ensure that the medication management system had a documented quarterly evaluation that included all requirements as outlined in the regulations.

Sources: The home's medication management quarterly report and minutes of

meetings; and an interview with the DOC.

WRITTEN NOTIFICATION: Annual Evaluation (Drugs)

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125
Annual evaluation
s. 125.
(1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.
(2) Where the pharmacy service provider is a corporation, the licensee shall ensure that a pharmacist from the pharmacy service provider participates in the annual evaluation.
(3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 124;
(b) be undertaken using an assessment instrument designed specifically for this purpose; and
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
(4) The licensee shall ensure that the changes identified in the annual evaluation are implemented.
(5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented.

The licensee has failed to ensure that the medication management system had a documented annual evaluation that included all requirements as outlined in the

regulations.

Sources: The home's medication management program annual report; and an interview with the DOC.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee has failed to ensure that the LTC home had established a continuous quality improvement committee (CQI).

Sources: Quality Advisory Committee Terms of Reference; and an interview with the Executive Lead of LTC.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that the Residents' Council and Family Council

received a copy of the home's annual CQI initiative report.

Sources: Residents' and Family Council Meeting Minutes; and interviews with a resident and the Executive Lead for LTC.

WRITTEN NOTIFICATION: Administrator

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 249 (1) 1.
Administrator
s. 249 (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.

The licensee has failed to ensure that the Administrator of the home worked in that position, on-site at the home, for the required hours.

Sources: Observations; and interviews with the DOC and Executive Lead for LTC.

COMPLIANCE ORDER CO #001 Air temperature

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
a) Develop and implement a plan to inspect the Heating, Ventilation, and Air Conditioning systems in all areas of the home to ensure they maintain a minimum temperature of 22 degrees Celsius. Fix any issues found. Document the inspection and repairs, keep the records on-site, and provide them to an inspector upon request.

b) Review and update the written process for monitoring air temperatures in the home. It must explain how temperatures are measured and monitored, list equipment designed for measuring air temperatues, outline corrective actions if temperatures fall below 22 degrees Celsius, and include evaluation methods to ensure compliance with the legislation.

c) Implement the updated process from part b), ensuring all staff responsible for monitoring air temperatures in the home receive training. Maintain records of the training sessions, including the names of the attendees.

Grounds
The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius on multiple days during a specified period.

Rationale and Summary
At the time of the inspection, two residents were observed wearing blankets in a common area. According to the residents, the area was often cold. The air temperatures taken by the Plant Maintenance Manager (PMM) confirmed the room temperature ranged from 21 to 21.4 degrees Celsius. During an additional observation of the room, the thermostat registered a temperature of 20 degrees Celsius, while multiple other resident rooms had readings below 22 degrees Celsius.

A review of the home's temperature monitoring logs for a specified period, also

revealed that temperatures were not maintained at a minimum of 22 degrees Celsius. The documents did not indicate any corrective actions were taken.

Failure to ensure a minimum temperature of 22 degrees Celsius in the home, caused discomfort and created an unpleasant living environment for residents.

Sources: Observations of the resident home area; the home's air temperature logs, and an email correspondence; and interviews with residents, a registered staff member, and the PMM.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #002 Menu planning

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 77 (2)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(a) is reviewed by the Residents' Council for the home;
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop a plan to ensure all menu items, including the residents' choices, are reviewed for nutritional adequacy by the home's Registered Dietitian (RD), considering current Dietary Reference Intake (DRIs) as required by O. Reg. 246/22, s. 77 (2) (c), before implementing the approved menu.

b) Outline how the plan will be developed in a timely manner, including the completion date and participants.

Grounds
The licensee has failed to ensure that all items on the Winter Menu were evaluated and approved for nutritional adequacy, considering the DRIs applicable to the resident population, by a RD prior to implementation.

Rationale and Summary
The home's Winter Menu included a weekly "Residents' Choice" dinner option, but no specific items were listed.

The review and approval document for the Winter Menu did not address the missing items or confirm that a nutrient analysis was conducted for the Winter Menu to ensure daily nutritional targets were met, as verified by the RD and the Support Services Manager.

There was a risk to residents in the home that the nutritional adequacy of the menu would not meet the residents' needs when the licensee did not ensure that all menu items were evaluated and approved by an RD while taking DRIs into account.

Sources: Menu Planning Checklist, Winter Menu, Residents' Choices document, and email correspondences; and interviews with a registered dietitian and the Support Services Manager.

This order must be complied with by June 30, 2025

COMPLIANCE ORDER CO #003 Emergency plans

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (8) (a)
Emergency plans
s. 268 (8) The licensee shall ensure that the emergency plans for the home are evaluated and updated,
(a) at least annually, including the updating of all emergency contact information of the entities referred to in paragraph 4 of subsection 268 (4)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Consult with specified entities in O. Reg. 246/22, s. 268 (3), to evaluate and update emergency plans to address all required components, including the loss of one or more essential services, evacuation, and any other emergency plan mandated by O. Reg. 246/22, s. 268 (4) that was not evaluated and updated in the past year.

b) Provide training to all staff, volunteers, and students on the updated emergency plans that were reviewed and revised in part a).

c) Keep records of the activities from parts a) and b) including agendas, minutes, attendance, changes made, implementation dates, training dates and attendees. Provide these records to an inspector upon request.

Grounds
The licensee has failed to ensure that the written emergency plan for the loss of one or more essential services, as well as for evacuation was evaluated and updated at least once a year.

Rationale and Summary

The home's emergency plan for loss of essential services and evacuation plans were not reviewed or updated annually.

Failure to evaluate and update the home’s emergency plans at least annually increased the risk of harm to residents.

Sources: The licensee's emergency plans and an email correspondence; and an interview with the PMM and Executive Lead for LTC.

This order must be complied with by June 30, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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