Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 5, 2013	2013_140158_0033	S-000287-13	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

KELLY-JEAN SCHIENBEIN (158)

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): September 25, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered staff, personal support workers,and residents.

During the course of the inspection, the inspector(s) reviewed the health care record of a resident, observed staff to resident interactions, reviewed various policies and procedures and reviewed staff employment records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. On September 25, 2013, the Inspector reviewed resident # 01 plan of care and the resident's behaviour charts (April to July 2013). The behaviour charts identified that resident # 01 became physically aggressive and resistive when care such as bathing, grooming, dressing was provided by the staff. Interventions, such as using a French speaking staff to deliver care, calling resident # 01 family were used. Although, resident # 01 plan of care identifies some interventions, the above interventions were not included. As well, the interventions in the plan of care were generic (maintain a regular routine, is physically abusive) and do not provide clear direction to staff and others to prevent and manage resident # 01 resistive/aggressive behaviour. [s. 6. (1) (c)]

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 plan of care sets out clear direction to staff and others who provide care to residents with resistive/aggressive behaviour, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. According to a Critical Incident, Staff # 101 and staff # 102 physically and emotionally abused resident # 01 in 2013. The home's "Duty to Report" policy was reviewed and identifies that abuse of a resident by anyone must be immediately reported. All reports should be made to the team members' immediate supervisor or manager. The DOC/ADOC would then report the incident to the Director if during business hours or the charge Nurse would report the incident by calling the Ministry's after hours pager.
The incident of abuse was observed by staff # 103 who informed staff # 104. Staff # 103 did not complete an incident report despite staff # 104 direction and subsequently the incident was not reported to the Director until a week later.
A previous incident of staff to resident abuse involving Staff # 101 occurred in 2011. This incident was not reported to the Director.
Education records show that staff # 101 last attended the mandatory abuse in-service "One is one too Many" in 2011 after the home's investigation of the 2011 incident. The licensee failed to protect its residents from abuse by anyone. [s. 19. (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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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. An incident of staff to resident abuse involving staff S-101 occurred in 2013 however it was not reported to the Director until a week later.
A previous incident of staff to resident abuse involving staff S-101 occurred in 2011 and was not reported to the Director.
A Written Notification was issued during the November 2012 Inspection # 2012_140158_0023 related to reporting requirements.
The licensee failed to immediately report the suspicion and the information upon which it is based, regarding staff to resident abuse, to the Director. [s. 24. (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 incidents of suspected or witnessed abuse is immediately reported to the Director, to be implemented voluntarily.

Issued on this 5th day of November, 2013

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