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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2014	2014_282543_0012	S-000157-14	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

TIFFANY BOUCHER (543), FRANCA MCMILLAN (544)

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 14th-25th, 2014

Ministry of Health and Long-Term Care Log #S-000171-14 was also inspected concurrently with the Resident Quality Inspection Log #S-000157-14.

During the course of the inspection, the inspector(s) spoke with Director of Nursing (for Rosedale Centre), Director of Nursing (Matheson, Iroquois Falls and Cochrane), Chief Nursing Officer, Registered Nurses, Registered Practical Nurses, Personal Support Workers/Health Care Aides, Physiotherapy Assistant, Residents and Family members

During the course of the inspection, the inspector(s)
- Directly observed the delivery of care and services to residents
- Conducted resident and family interviews
- Conducted daily tour of all resident home areas
- Directly observed dining and meal delivery service
- Observed fluid and nourishment passes
- Reviewed resident health care records
- Reviewed staffing patterns for RNs, RPNs and PSWs
- Reviewed various home policies and procedures

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
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. Inspector #544, reviewed resident #2751's most recent Care Plan which identified resident was receiving physiotherapy three times per week by Phyisotherapy Assistant. After further review of resident #2751's health care record, documentation from Physiotherapist identified that resident #2751's physiotherapy file was closed. Phyisotherapy Assistant confirmed that resident #2751 had been discharged from physiotherapy services on September 18,2013.
Consequently, the licensee did not ensure that there is a written plan of care for resident #2751 that sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector #544 reviewed the Home's Policy-Pain Management Program (P-05). Policy identified that all direct care staff must receive annual training/re-training on pain management. Inspector #544, reviewed staff education attendance sheets and identified that only 26% of direct care staff were re-trained in 2013. Inspector spoke with Director of Nursing, who confirmed that in fact there is no further documentation available in regards to Pain Management training for the year 2013.
Consequently, the licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Inspector #543 spoke with Director of Nursing, regarding annual training and retraining of staff in regards to the Abuse Policy and Procedures in the home. Director of Nursing, confirmed that not all staff have been retrained annually. The home's policy states that the home will provide annual and ongoing education regarding abuse and neglect. Director of Nursing, confirmed that the list of staff that attended education sessions is accurate, and in fact not all staff had attended training for the year 2013.
Therefore, the licensee did not ensure that their written policy that promotes zero tolerance of abuse and neglect of resident was complied with. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. Inspector #543 determined that the home does not have a Family Council. In speaking with, the assistant for the Resident's Council and the Director of Nursing, it was confirmed that the licensee has not convened semi-annually to advise residents' families and persons of importance of their right to establish a Family Council. [s. 59. (7) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 120. Responsibilities of pharmacy service provider
Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
2. Evaluation of therapeutic outcomes of drugs for residents.
3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
5. Educational support to the staff of the home in relation to drugs.
6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. Inspector #544, spoke with the Pharmacist from the pharmacy service provider, who confirmed that he is not fully aware of his responsibilities with respect to Long-Term Care Homes, as a pharmacy provider. Pharmacist also confirmed that he does not participate in the development of medication assessments and reassessments. Therefore, the licensee failed to ensure that the pharmacy provider participates in the following activities: the development of medication assessments and records for medication reassessments, for each resident of the home. [s. 120. 1.]

2. Inspector #544 interviewed the Director of Nursing for Rosedale, the Director of Nursing for Long-Term Care for MIC (Matheson, Iroquois Falls and Cochrane) and the Chief Nursing Officer for MIC. They confirmed, that there are no records, documentation or a pharmacy program that ensures the pharmacy service provider participates in the evaluation of the therapeutic outcomes of drugs for residents. [s. 120. 2.]

3. Inspector #544 interviewed the Director of Nursing for Rosedale, the Director of Nursing for Long-Term Care for MIC (Matheson, Iroquois Falls and Cochrane) and the Chief Nursing Officer for MIC. They confirmed, that there are no records, documentation or a pharmacy program that ensures the pharmacy service provider participates in risk management and quality improvement activities, including review of

medication incidents, adverse drug reactions and drug utilization. [s. 120. 3.]

4. Inspector #544 interviewed the Director of Nursing for Rosedale, the Director of Nursing for Long-Term Care for MIC (Matheson, Iroquois Falls and Cochrane) and the Chief Nursing Officer for MIC. They confirmed, that there are no records, documentation or a pharmacy program that ensures that the pharmacy provider participates in developing audit protocols for the pharmacy service provider to evaluate the medication management system. [s. 120. 4.]

5. Inspector #544 interviewed the Director of Nursing for Rosedale, the Director of Nursing for Long-Term Care for MIC (Matheson, Iroquois Falls and Cochrane) and the Chief Nursing Officer for MIC. They confirmed, that there are no records, documentation or a pharmacy program that ensures the pharmacy service provider participates in educational support to the staff of the home in relation to drugs. Inspector also reviewed the staff education training attendance records, and could not find any documentation or records that identified that the pharmacy provider participates in educational support to the staff of the home in relation to drugs.

Consequently, the licensee did not ensure that the pharmacy provider participates in the development of educational support to the staff of the home in relation to drugs. [s. 120. 5.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. Inspector #544 reviewed the home's Policy- Continence Care and Bowel Management Program (C-50) which describes the policy, including but not limited to toileting and peri-care. The policy also identifies, procedures to follow, roles and responsibilities (of interdisciplinary team), interventions as well as methods of monitoring and evaluating the policy. There are 25 staff members who provide direct care to residents at the home, of the 25, 2 are on leave.
Inspector #544 reviewed training and education records and identified that 2 of the 10 personal support workers and 4 of the 13 Registered Practical Nurses received training in Continence Care and Bowel Management for 2013.
The home's Policy- Continence Care and Bowel Management Program (C-50) states that a record of annual evaluation of the program as well as the effectiveness of the continence care and bowel management products will be kept; and will include the name and relevant discipline of the individuals participating in the review. A summary of any changes arising from the review and an action plan outlining the timelines for the implementation of the changes will be recorded.
Inspector #544 spoke with the Director of Nursing who confirmed that there are no further records of attendance or documentation of a review in this program for 2013.
Consequently, the licensee did not ensure that training related to Continence Care and Bowel Management was provided to all staff who provide direct care to residents, on an annual basis. [s. 221. (1) 3.]

2. Inspector #543 spoke with the Director of Nursing (DON) regarding annual training and retraining of staff in regards to the Responsive Behaviours policy in the home. DON confirmed that not all staff have been retrained annually. The home's policy states that all staff, contractors providing direct care and volunteers must be oriented prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behaviour management. DON confirmed that the list of staff that attended education sessions is accurate, and in fact not all staff had attended training for 2013.
Consequently, the licensee did not ensure that all direct care staff received the training annually as required in subsection 76 (7) of the Act. [s. 221. (2),s. 221. (2) 1.]

WN #7: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector #543 reviewed 3 randomly picked residents' immunization records and it was identified that there is no documented history of screening for TB. Inspector #543 spoke with staff, requesting any information/records the home has in terms of TB screening or proof of screening for TB. The home was unable to provide any information. Inspector #543 spoke with Director of Nursing, who confirmed that the home is unable to provide documentation of TB screening for residents in the home. Therefore, documentation of this screening is not available to the licensee. [s. 229. (10) 1.]

Issued on this 22nd day of May, 2014

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