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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2015	2015_320612_0022	019181-15	Follow up

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

SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 26 and 27, 2015

During the course of the inspection, the inspector(s) spoke with Residents, the Director of Nursing, the RAI Coordinator, Personal Support Workers and Registered Practical Nurses.

The inspector also conducted a daily tour of the long-term care unit, reviewed residents' health care records, observed staff to resident interactions, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2015_281542_0009	612
LTCHA, 2007 S.O. 2007, c.8 s. 33. (4)	CO #001	2015_281542_0009	612

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. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to the resident.

Inspector reviewed resident #003's care plan and noted the following intervention which was initiated on September 17, 2015:
- Droplet isolation

Inspector went to resident #003's room and did not observe any isolation signage or equipment.

Inspector reviewed resident #003's health care record and noted a progress note from September 20, 2015 which stated that the isolation was discontinued.

Inspector interviewed S#100 and S#103 who confirmed that resident #003 was no longer on isolation and that their plan of care did not provide clear direction. [s. 6. (1) (c)]

Issued on this 28th day of October, 2015

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

Original report signed by the inspector.