Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Nov 6, 15, 16, 2012	2012_140158_0023	Critical Incident

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 Inspection.

During the course of the inspection, the inspector(s) spoke with the 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 identified in the critical Incident report, and observed resident to resident interactions and staff to resident interactions.

Log # S-001255-12 was reviewed during this inspection.

The following inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The home submitted a mandatory report to the Director identifying alleged resident to resident abuse five days after the incident occurred. The licensee did not immediately report the suspicion and the information upon which it is based regarding of resident to resident abuse to the Director. [LTCHA 2007, S.O. 2007, s. 24 (1) 2]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee submitted a Critical Incident Report to the Director identifying that residents were fearful of resident # 01 verbal aggression and threats to do harm to them.
The health care record, including, progress notes, the plan of care, and assessments for resident # 01 were reviewed by the Inspector on November 6, 2012.
It was documented in resident # 01 progress notes that there were five episodes of resident # 01 displaying responsive behaviours in September 2012 and one episode of the resident displaying responsive behaviours in October 2012.
The quarterly assessment for resident # 01 identified that resident # 01 displays responsive behaviours on a daily basis.
Staff # S-100 stated to the Inspector that the home is following the draft version of the home's Responsive Behaviour Program. It is identified in the home's Responsive Behaviour Program that each resident will have a plan of care that includes: a precise description of the behaviour, identification of the level of risk, triggers,interventions, objectives, the medication regime and reassessment time frames. The plan of care for resident # 01 was reviewed by the Inspector and it does not identify any of resident # 01 documented behaviours or strategies to respond to his behaviours.
The licensee did not ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours. [O Reg 79/10, s. 53 (4) (b)]

Issued on this 16th day of November, 2012

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