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
Direction de l'amélioration de la performance et de la conformité

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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
Dec 14, 2015	2015_195166_0026	030088-15	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

Long-Term Care Home/Foyer de soins de longue durée

HIGHLAND WOOD
7199 Gelert Road P.O. Box 115 HALIBURTON ON K0M 1S0

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

CAROLINE TOMPKINS (166), LYNDA BROWN (111)

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): November 16,17,18,19, 2015

Complaint Log O-002794-15 related to allegations of staff to resident abuse was inspected concurrently during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Resident and Family Council Representatives, CEO, Director of Care, Assistant Director of Care, RAI Coordinator, Dietary Aides, Housekeeping Aides, Life Enrichment Program Manager, Environmental Manager, Registered Nurses, Registered Practical Nurses and Personal Support Workers.
The Inspectors also observed staff to resident and resident to resident interactions, observed 2 meal and nourishment services, toured resident rooms and common areas, observed medication administration and infection control practices.
Clinical health records, licensee's investigation documentation, the licensee's policies related to infection control, resident abuse prevention program and pain and symptom management were reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident’s health condition and for which the resident is taken to a hospital.

Review of the health record for resident #006 indicated on specific date and time the resident was found with an injury that required transfer to the hospital for assessment. The resident sustained a injury that resulted in a significant change in the resident’s health condition and required the use of a medical intervention.

Interview of the CEO indicated there was no critical incident report submitted to the Director for this incident.(111)

2.Review of clinical records and interview with resident #23 and RN #100 indicated that on a specified date, while the resident was away from the home, the resident sustained an injury that required transfer to the hospital for further assessment and medical treatment. There is no evidence to indicated the Director was informed of the incident.

Interview with the Director of Care confirmed that the Director was not notified of the incident that caused an injury to resident #23 that resulted in a significant change in the resident’s health condition and for which the resident is taken to a hospital.(166)

This same non-compliance was issued on August 28, 2013 during inspection #2013_031194_0032 and issued again November 3, 2014 during inspection #2014_288549_0040. During this inspection, there were two residents who sustained injuries that resulted in a significant change of condition and for which the residents were taken to the hospital. These incidents were not reported to the Director and the home did not determine the cause of the injury sustained by resident #006. [s. 107. (3) 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident was reassessed, and the plan of care was reviewed and revised when the resident's care needs changed related to an injury and pain.

Review of the progress notes for resident #006 indicated on a specific date and time, a Personal Support Worker reported the resident has sustained a possible injury and was having difficulty with standing. The resident was then transferred to hospital for assessment and treatment.There is no evidence to indicate if the resident was reassessed post injury. There was also no indication the resident received any breakthrough analgesic after the evening the injury was identified.

Review of the care plan for resident #006 had no indication the care plan was revised to include pain or related to the new injury. [s. 6. (10) (b)]

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 to ensure that when any residents' care needs change, the resident is reassessed and the plan of care is reviewed and revised accordingly, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of the home's policy "Pain and Symptom-Assessment and Management Protocol" (VII-G-70.00) revised February 2014, indicated the Registered staff will conduct and document a pain assessment when there is a change in condition with pain onset, diagnosis of a painful disease utilizing PCC pain assessment.
Initiate a 24 hr Pain and Symptom Monitoring Tool when: a scheduled pain medication does not relieve the pain, and when pain medication is changed.

Related to resident #006:
Review of the progress notes indicated that on a specific date and time the Personal Support Worker reported to charge nurse, the resident has sustained a possible injury and was having difficulty with standing. The resident was assessed and transferred to the hospital. The resident sustained a injury that resulted in a significant change in the resident’s health condition and required the use of a medical intervention. Review of the clinical assessments had no documented evidence of a pain assessment completed related to change in condition, new onset of pain, and diagnosis of fracture.

Related to resident #010:
Review of health record indicated the resident developed altered skin integrity. There was no indication a pain assessment was completed when the resident had a change in condition.
When the resident developed further concerns related to skin integrity, the resident's analgesic order was increased due to the increased use of a PRN analgesic. There was no indication a pain assessment or a Pain and Symptom Monitoring Tool was completed at that time when the resident's pain was not managed, and the pain medication was changed, as per the home's policy. [s. 52. (2)]

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 to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are served using methods which prevent adulteration, contamination and food borne-illness.

During the observation of the noon meal service on November 16, 2015 at 1230h, two Personal Support Workers serving the soup were observed removing crackers from the package with their hands and placing the crackers at residents' table without using a tong or hand hygiene in between each resident. There were no tongs provided for the Personal Support Workers.

Observation of noon meal dining service on November 18, 2015 indicated Dietary Aide #103 had provided 2 tongs to for the distribution of the crackers. Personal Support Workers #104 stated she preferred to use gloves instead of tongs and the Dietary Aide provided the Personal Support Worker with gloves.
The Personal Support Worker was then observed touching resident tables, servery counter and tray with same gloved hands after approaching each resident table. The Personal Support Worker then touched the crackers with the same pair of gloves throughout the entire service of providing soup.
Observation of the afternoon nourishment indicated two Personal Support Workers were observed handing out cookies wearing the same pair of gloves through the entire unit without hand washing. [s. 72. (3) (b)]

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 to ensure that all food and fluids are served using methods which prevent adulteration, contamination and food borne-illness, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents’ Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents’ Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee document and make available to the Resident's Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Interview of the Resident Council President (resident #010) indicated, could not recall the management reviewing the results of the satisfaction survey. Telephone interview with the Life Enrichment Program Manager(LEPM) indicated she was the liaison person representing the home for the Resident Council and completed the meeting minutes each month.The LEPM indicated she could not recall reviewing the results of a resident satisfaction survey with the residents in 2015.

Review of the Resident Council Meeting minutes for 2015 indicated no documented evidence that the results of the resident satisfaction survey were discussed at any of the meetings in 2015.

Interview of CEO indicated that the resident satisfaction survey was sent out in February 2015 and results were reviewed and action plan put in place. The CEO indicated the results of the survey were discussed with the Family Council but not with the Resident Council. [s. 85. (4) (a)]

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 to ensure that the licensee document and make available to the Resident's Council the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language.

Review of the RAI MDS assessments indicate that resident #029 has communication difficulties
and will sometimes miss the intent of the message, evident by the wrong actions or repeating the message back to speaker incorrectly.
Resident #029 was observed with communication aids in place and during an interview it was noted that the resident displayed some difficulty when responding to the conversation.
There is no evidence that resident #029's plan of care addresses the use of equipment to assist the resident with communication. [s. 26. (3) 3.]

Issued on this 14th day of December, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLINE TOMPKINS (166), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2015_195166_0026
Log No. / Registre no:	030088-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 14, 2015
Licensee / Titulaire de permis :	HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	HIGHLAND WOOD 7199 Gelert Road, P.O. Box 115, HALIBURTON, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Varouj Eskedjian

To HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

The licensee shall ensure that all significant supervisory and nursing staff are given formal instruction on reporting to the Director any incident that causes injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to the hospital.
The licensee shall put into place a monitoring process to ensure that all these incidents are reported to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital

1. Review of the health record for resident #006 indicated on specific date and time, the resident was found with an injury that required transfer to the hospital for assessment. The resident sustained a injury that resulted in a significant change in the resident's health condition and required the use of a medical intervention.

Interview of the CEO indicated there was no critical incident report submitted to the Director for this incident.(111)

2. Review of clinical records and interview with resident #23 and RN #100 indicated that on a specified date, while the resident was away from the home, the resident sustained an injury that required transfer to the hospital for further assessment and medical treatment. There is no evidence to indicated the Director was informed of the incident.

Interview with the Director of Care confirmed that the Director was not notified of the incident that caused an injury to resident #23 that resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital.(166)

This same non-compliance was issued on August 28, 2013 during inspection #2013_031194_0032 and issued again November 3, 2014 during inspection #2014_288549_0040. During this inspection, there were two residents who sustained injuries that resulted in a significant change of condition and for which the residents were taken to the hospital. These incidents were not reported to the Director and the home did not determine the cause of the injury sustained by resident #006. [s. 107. (3) 4.](111) (166)

2. . (166)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** Dec 28, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of December, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CAROLINE TOMPKINS

Service Area Office / Bureau régional de services : Ottawa Service Area Office