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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2019	2018_643111_0021	025334-17, 002478-18	Critical Incident System

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

LYNDA BROWN (111)

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): October 31, November 1 and 2, 2018. Off-site on November 29, 2018.

There were two critical incident inspections completed concurrently during this inspection related to falls with injury as follows:
-Log #025334-17 (CIR) and Log # 002478-18 (CIR)

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPN), Resident Care Coordinator (RCC) (falls lead), and Personal Support Workers (PSW).

During the course of the inspection, the inspector: observed residents and resident rooms, reviewed health care records of current and deceased residents, reviewed resident safety committee meetings and reviewed the licensee's Falls Prevention and Managements Program.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised, because care set out in the plan has not been effective, that different approaches had been considered in the revision of the plan of care.

Related to log # 025334-17 and 002478-18:

There were two critical incident reports submitted to the Director for resident #001 related to falls with injury as follows:
-Log # 025334-17: Critical incident report (CIR) was submitted to the Director for a fall with injury for which the resident was transferred to hospital. The CIR indicated on a specified date and time, a PSW reported to RPN #100 that resident #001 was found on the ground in an outdoor area. The resident sustained injuries to specified areas and had complaints of pain to specified areas. The resident was transferred to hospital and diagnosed with a specified injury to a specified area. The CIR was completed by the DOC.
-Log # 002478-18: Critical incident report (CIR) was submitted to the Director for a fall with injury for which the resident was transferred to hospital. The CIR indicated on a specified date and time, resident #001 sustained a fall in their room. The resident had sustained an injury to a specified area and complained of pain to a specified area. The resident was transferred to hospital, diagnosed with an injury to a specified area and returned to the home on palliative care. The CIR indicated the resident had sustained a specified number of falls since admission. The CIR indicated was completed by the DOC.

In addition, review of the progress notes and fall incident reports for resident #001, indicated the resident sustained a specified number of falls since admission, over a specified period.

During an interview with the DOC, the DOC indicated awareness of resident #001 sustaining multiple falls and the home had tried different specified interventions. The DOC could not recall when each of the interventions were put in place. The DOC indicated resident #001 was trailed with a specified fall protective device but the resident found the device disturbing, so the home switched to a different fall protective device.

During an interview with the Falls Lead (RPN #103), the RPN indicated they had only been in the role after resident #001 had died. The RPN indicated the previous falls lead was off on leave. The RPN indicated all resident falls were reviewed monthly at the

"resident safety committee meetings" and any interventions identified to prevent a recurrence or to reduce the severity of injury from falls, was noted on the "resident fall prevention and management form" for each resident.

Review of the resident safety committee meeting minutes and the resident fall prevention and management forms over a specified period for resident #001 indicated during four separate meetings, the resident was identified as a high risk for falls and identified a specified number of interventions.

Review of the High Intensity Needs application indicated resident #001 had one to one monitoring in place over a specified period as an intervention.

Review of the plan of care (in place at the time of the falls) for resident #001 indicated, the resident required extensive assistance with mobility. The resident was a high risk for falls. There were specified interventions identified.

Resident #001 had sustained a number of falls in five months, with two of the falls resulting in injuries to specified areas that required transfer to hospital. When interventions in place were not effective, new specified interventions were not considered until after a number of falls, which resulted in an injury to a specified area. An additional specified interventions were suggested by the resident safety committee but were not indicated in the written plan of care, nor were two other specified interventions. After an additional fall, the resident safety committee suggested an additional intervention but there was no indication whether this intervention was implemented and was suggested again after additional falls. The committee also indicated the resident was to be escorted to and from meals and a specified fall protective device was changed but the care plan was not revised to reflect these interventions. The resident had also requested a specified device for the their room but this was not completed until after a number of falls. The resident safety committee indicated both specified fall protective devices were discontinued despite the resident continuing to fall. Three specified interventions for fall prevention were not identified or implemented until after the resident sustained a second injury to a specified area that required transfer to hospital and these interventions were also not indicated in the written plan of care.

The licensee has failed to ensure that when resident #001 was being reassessed and the plan of care was being revised related to falls, because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

2. Related to resident #002:

During an interview with the DOC, the DOC indicated resident #002 was a high risk for falls.

Observation of resident #002 on a specified date and time, indicated the resident was in bed with specified fall prevention interventions in place.

Review of the progress notes and falls incident reports for resident #002 indicated, the resident had sustained a number of falls over a specified period. A number of the falls resulted in injury or pain to a specified area and one of the falls resulted in an injury to a specified area requiring transfer to hospital.

During an interview with PSW# 107, the PSW indicated resident #002 was previously at moderate risk for falls and had specified, fall protective interventions. The PSW indicated the resident had declined in health and no longer a fall risk.

During an interview with PSW #108, the PSW indicated resident #002 was previously a high risk for falls, but no longer a fall risk. The PSW identified specified fall protective interventions that were in place currently in place. The PSW indicated the resident no longer used a specified fall protective device.

Review of the resident safety committee meeting minutes and the resident fall prevention and management forms for resident #002 over a specified period indicated, the resident was initially identified as at moderate risk for falls and then changed to a high risk for falls. There was also a specified number of interventions identified.

Review of the health care record for resident #002 indicated the resident had a diagnosis that related to a prior injury, to a specified area, from a previous fall. Review of the current written plan of care for resident #002 indicated a number of specified interventions. Different approaches were not considered until after the resident sustained a fall with an injury to a specified area and some of the interventions were noted to be ineffective, but continued to be implemented. Resident #002 had sustained a number of falls, with most of the falls occurring over an identified period. The fourth fall resulted in injury to a specified area and required transfer to hospital.

The licensee has failed to ensure that when resident #002 was being reassessed and the

plan of care was being revised related to falls, because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

3. Related to resident #003:

During an interview with the DOC, the DOC indicated resident #003 was a high risk for falls.

Observation of resident #003 on a specified date and time, indicated the resident was in bed, with identified fall prevention interventions in place. Later, the resident was observed up in a mobility aid and was not interviewable.

Review of the health care record of resident #003 indicated the resident had diagnoses related to a prior fall that resulted in an injury to a specified area (prior to admission). The progress notes and fall incident reports indicated the resident sustained a number of falls over a specified period. Two of the falls resulted in an injury to a specified area and one of the falls resulted in an injury to a specified area requiring transfer to hospital.

Review of the resident safety committee meeting agenda, minutes and resident fall prevention and management forms for resident #003 indicated the resident was at high risk for falls and had identified specific interventions.

Review of the current written plan of care for resident #003 indicated the resident was at risk for falls. There were specified interventions identified.

During an interview with PSW #106, the PSW indicated resident #003 usually remained in bed until a specified time (at family request). The PSW indicated residents #003 used to be at high risk for falls but was now palliative.

The licensee has failed to ensure that when resident #003 was being reassessed and the plan of care was being revised related to falls, because care set out in the plan had not been effective, as the resident had sustained a number of falls over a specified period, that different approaches had been considered in the revision of the plan of care.

Additional Required Actions:

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

Issued on this 18th day of January, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2018_643111_0021
Log No. / No de registre :	025334-17, 002478-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 15, 2019
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 :	Michelle Douglas

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The Licensee shall be compliant with LTCH Act, 2007, s.6(11)(b).

Specifically, the licensee shall:

1. Develop, implement and keep a record of a process which includes the review of all residents at moderate to high risk for falls (in accordance to the fall risk assessment tool results). Those residents identified as moderate to high risk for falls, will have the written plan of care reviewed to ensure that all interventions in place are effective and applicable, in reducing falls or reducing the potential for injury from falls. The plan of care will also be revised, for those residents whose interventions are determined to be ineffective and different approaches will be considered in the revision.

2. Develop and implement a structured Falls Prevention Committee, with clear directions as to who will be responsible to lead for the committee, what tools will be used in falls preventions, how frequently the committee will meet and how the meeting minutes will be documented. There will also be clear direction how any falls prevention interventions discussed at each of the meetings will be provided to front line staff, so that all staff who provide direct care to those residents, are aware of each resident at moderate to high risk for falls, current interventions in place for falls prevention.

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised, because care set out in the plan has not been effective, that different approaches had been considered in the revision of the plan of care.

Related to log # 025334-17 and 002478-18:

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specified area that required transfer to hospital and these interventions were also not indicated in the written plan of care.

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Review of the resident safety committee meeting agenda, minutes and resident fall prevention and management forms for resident #003 indicated the resident was at high risk for falls and had identified specific interventions.

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During an interview with PSW #106, the PSW indicated resident #003 usually remained in bed until a specified time (at family request). The PSW indicated residents #003 used to be at high risk for falls but was now palliative.

The licensee has failed to ensure that when resident #003 was being reassessed and the plan of care was being revised related to falls, because care set out in the plan had not been effective, as the resident had sustained a number of falls over a specified period, that different approaches had been considered in the revision of the plan of care.
The scope was a level 3, widespread as three out of three residents at high risk for falls, did not have the plan of care reviewed and revised when interventions were determined to not be effective in reducing falls or reducing the severity of falls. The severity was a level 3, actual harm as the three residents all had serious injuries as a result of falls and one resident subsequently died post fall (resident #001). The compliance history was a level 3,non-compliance in similar areas as follows: the home was issued a Voluntary Plan of Correction (VPC) on October 6, 2017 during an RQI for s. 6(1)(c) related to falls and issued a VPC for s. 6(10)(b) on December 14, 2015 during the RQI. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office