Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2019	2019_694166_0016	030929-18, 001387-19, 002863-19, 011555-19, 013199-19	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

CAROLINE TOMPKINS (166)

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): July 8, 9,10,11,12, 2019

The following intakes were completed concurrently in this Critical Incident System inspection:
Log #002863-19 - related to late reporting.
Log #013199-19 - related to a resident to resident physical altercation.
Log #030929-19 - related to a fall.
Log #011555-19 - related to a missing resident.
Log #001387-19 - related to a follow up to Compliance Order #001.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Administrator/Director (ADM/DOC), Chief Executive Officer (CEO), Resident Care Coordinator (RCC), Behavioural Support Ontario (BSO) staff member, Personal Support Workers (PSW), Registered Practical Nurses (RPN) and the Director of Facilities and Projects.

During the course of this inspection, the inspector toured residents' home, common and non resident areas, observed staff to resident and resident to resident interactions. The Inspector reviewed clinical health records, documentation related to the home's evacuation due to a roof leak, the repatriation of residents and relevant policies related to this inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **2 WN(s)**
- **2 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2018_643111_0021	166

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004, as specified in the plan.

Related to Log #030929-18:

On an identified date, a Critical Incident Report (CIR) was submitted to the Director, reporting that resident #004 was transferred to the hospital following a fall.

Review of the CIR documentation indicated on an identified date and time, resident #004 had fallen and had sustained an injury that required further treatment at the hospital.

Review of resident #004's plan of care related to high risk for falls, indicated several interventions were to be in place to mitigate falls and /or injury from falls.

During an interview with Resident Care Coordinator (RCC) #106, the lead for Resident Safety Committee (Falls), indicated resident #004 was not independently mobile but was able to reposition independently when in bed.

Review of the falls risk management report related to this fall and during an interview with the Administrator/Director of Care (ADM/DOC) indicated that when resident #004 fell, two of the interventions in the plan of care to mitigate and alert staff to a fall were not in place.

During an interview with Inspector #166, PSW #107, who assisted resident #004 to bed on the identified date of the incident, indicated that the PSW did not have any recollection related to ensuring all interventions as directed in the plan of care were in place.

The care set out in the plan of care related to ensuring that all interventions related to the high risk of falls when resident #004 was in bed was not provided to the resident as directed in the resident's plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.s.9 (1)

Related to Log #011555-19:

On an identified date a Critical Incident Report, reporting a missing resident was submitted to the Director.

Review of the CIR documentation indicated that on identified date and time, resident #003 was noted to be missing. The Charge Nurse was notified and an immediate search was carried out within the home, outside the home and within the hospital which is attached to the Long Term Care Home. The PSWs found the resident, unharmed in a non- resident area.

Review of the CIR documentation indicated, the home's maintenance staff had brought service personnel into this area on the identified date.

Review of clinical documentation by Inspector #166 indicated, on the identified date, the staff safely brought the resident back to the home area. Resident #003 appeared to have no recollection of the incident and no negative sequela related to the incident.

During an interview with the Director of Care/Administrator (DOC/ADM) indicated the door to the non-resident area has always been locked, however since residents having been moving back into the home, service contractors have been entering this area. The DOC/ADM indicated the lock on that door has been changed to ensure that the door, when closed will now self-lock.

During an interview with Inspector #166, the Director of Facilities and Projects, advised that when the service contractor had finished their task, the Director of Facilities and Projects, acknowledged that the door to the non-resident area did not get locked. At the time of the incident the door required a key to lock.

Observation of the door locking system at the time of this inspection, indicated a new self- locking system had been put into place that ensures the door immediately locks

when closed, denying residents from entering that non-residential area.

The licensee has failed to ensure that the door leading, a restricted non-resident area was locked, thus allowing resident #003 access. [s. 9. (1)]

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 doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, or doors that residents do not have access to must be, kept closed and locked, to be implemented voluntarily.

Issued on this 18th day of July, 2019

[redacted]

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

Original report signed by the inspector.