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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2013	2013_031194_0032	000803-13	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

CHANTAL LAFRENIERE (194)

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): August 28, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Physio Therapist (PT),Physio Therapy Aides (PTA), Registered Nurse (RN), Personal Support Worker (PSW) and three Residents

During the course of the inspection, the inspector(s) reviewed clinical health records for identified residents, four Critical Incident Reports, licensee's policy for "Falls Prevention and Management" internal incident reports, Medication Administration Records (MARS)and the observation of staff/resident provision of care

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

Findings of Non-Compliance were found during this inspection.

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

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

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 failed to comply with LTCHA, 2007 s. 6(1)(c) when the plans of care for residents #1,#2 and #3 did not set out clear direction to staff and others who provide direct care.

Resident #1 had 5 un-witnessed falls over a two month period. Resident #1 sustained a fractured hip on the fourth fall. Three days after returning to the home post surgery, resident #1 fell a fifth time, re-fracturing the hip.
-The written plan of care for resident # 1 was not revised to provide clear direction to staff related to falls and care of hip fracture, until six days after returning home from the second surgery.

Resident #2 fell resulting in a fracture.
There is no evidence that the plan of care for resident #2, sets out planned care, goals or clear direction to staff related to cast care of the fracture.

Resident # 3 fell resulting in a fracture.
There is no evidence that the plan of care for resident #3 was revised after the fall, providing goals and clear direction to staff related to the care of the fracture and risk of falls.[s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA, 2007 s. 6(10)(b) when resident #1, #2 and #3s plans of care was not revised when the residents' care needs changed.

Resident #1 had 5 falls over two months, resulting in two fractures, changing the resident's care needs. The plan of care for resident #1 was not revised to promote prevention of falls and provision of care for transferring and toileting, until six days after returning from second surgery.

Resident #2 had a fall resulting in a fracture. The plan of care was not revised to identify the change in condition until three months after the fall.

Resident #3 had a fall resulting in a fracture. The plan of care was not revised to identify the change in condition. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, s. 8(1) (b) when the licensee's policy for falls management was not complied with

As per legislative requirements O.Reg S.48(1)1 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a Falls Prevention and Management Program to reduce the incidence of falls and risk of injury

Review of the licensee's Fall Prevention & Management policy # VII-G-60.00 dated May 2012 directs staff to:
-conduct the falls risk assessment in Point Click Care (PCC) at the following times;
-within 24 hours of admission
-ensure that preventative interventions are included in the resident's care plan
-monitor the preventative interventions and evaluate effectiveness on an ongoing basis and with the quarterly review
-initiate a head injury routine if a head injury is suspected, or if the resident fall is un-witnessed and he/she is on anticoagulants
-Monitor Head Injury Routine (HIR) for 48 hours post fall for signs of neurological changes.(see HIR policy VII-G-10.22)
-complete falls incident report.

Review of Licensee's policy "Fall Prevention & Management" Policy # VII-G-60.00 dated May 2013 directs staff to:
-conducted the falls risk assessment in Point Click Care (PCC) at the following times
-as triggered by the MDS resident Assessment Protocol
-when analysis of the triggered RAP indicates further assessment is needed
-within 24 hours of admission or re-admission
-when there is a physiological, functional or cognitive change in status
-ensure that preventative interventions are included in the resident's care plan
-monitor the preventative interventions and evaluate effectiveness on an ongoing basis and with the quarterly review

POST FALL ASSESSMENT
- Initiate a head injury routine if a head injury is suspected or if the resident fall is un-witnessed and he/she is on anticoagulant therapy
- Monitor HIR for 48 hours post fall for signs of neurological changes,
- Re-evaluate the resident's care plan, make the appropriate interdisciplinary referrals,

and document appropriate interventions to be taken.

Licensee's Policy for "Head Injury" VII-G-1-.22 dated May 2013 directs;
All un-witnessed resident falls will be assessed for a potential head injury.

Review of the clinical health record for resident #1 indicates 5 un-witnessed falls in two months.
-there were no preventative interventions included in the resident's written plan of care
-there were no monitoring of the preventative interventions and evaluation of effectiveness on an ongoing basis.
-there were only 3 falls incident reports completed for 5 documented falls.
-there was no HIR initiated for the 5 un-witnessed falls.

Resident #2 had a fall resulting in a fracture.
-There was no evidence that a Falls Risk assessment was completed post fall for resident #2
-There was no preventative interventions included in the resident's care plan [s. 8. (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 ensuring that the licensee's policy "Falls Prevention and Management" is to be complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 49(2) when resident # 1 had two falls and no clinically appropriate assessment was completed to assess the falls.

Resident # 2 fell resulting in an injury and no clinically appropriate assessment was completed to assess the fall. [s. 49. (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 ensuring that when a resident has fallen a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: 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):
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. O. Reg. 79/10, s. 107 (3).
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.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
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).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s. 107(3)4 when the Director was not notified within one business day of an injury in respect of which a resident is taken to hospital

-Resident #1 was sent to hospital post fall. MOHLTC was notified of incident 45 days later.
-Resident #1 was sent to hospital post fall. MOHLTC was notified of incident 4 days later.
-Resident #3 was sent to hospital post fall. MOHLTC was notified of incident 6 days later. [s. 107. (3)]

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 ensuring that the Direction is informed no later than one business day when an injury in respect of which a resident is taken to hospital, to be implemented voluntarily.

Issued on this 18th day of September, 2013

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

Chantal Lafrenière (194)

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

Ministére 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

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) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2013_031194_0032
Log No. / Registre no:	000803-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 16, 2013
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 :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the written plans of care for all residents at risk for falls including resident's #1, #2 and #3
-sets out planned care for the prevention of falls
-provides goals to ensure the safety of the residents at risk for falls
-sets out clear direction to staff and other who provide care to residents with fractures

Grounds / Motifs :

1. Resident #1 had 5 un-witnessed falls over a two month period. Resident #1 sustained a fractured hip on the fourth fall. Three days after returning to the home post surgery, resident #1 fell a fifth time, re-fracturing the hip.
-The written plan of care for resident # 1 was not revised to provide clear direction to staff related to falls and care of hip fracture, until six days after returning home from the second surgery.

Resident #2 fell resulting in a fracture.
There is no evidence that the plan of care for resident #2, sets out planned care, goals or clear direction to staff related to cast care of the fracture.

Resident # 3 fell resulting in a fracture.
There is no evidence that the plan of care for resident #3 was revised after the fall, providing goals and clear direction to staff related to the care of the fracture and risk of falls. (194)

2.
(194)

3.
(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2013

Order # / Ordre no : 002

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that all residents are reassessed and the plans of care are revised when the residents' care needs change.

The plans of care for residents #1, #2 and #3 will be revised to identify the changes in condition and indicate the risks associated with falls and post fracture injury.

Grounds / Motifs :

1.
(194)

2. Resident #1 had 5 falls over two months, resulting in two fractures, changing the resident's care needs. The plan of care for resident #1 was not revised to promote prevention of falls and provision of care for transferring and toileting, until six days after returning from second surgery.

Resident #2 had a fall resulting in a fracture. The plan of care was not revised to identify the change in condition until three months after the fall.

Resident #3 had a fall resulting in a fracture. The plan of care was not revised to identify the change in condition. on. (194)

3. Resident #3 had a fall on August 8, 2013 resulting in a left hip fracture.

The plan of care for resident #3 was not revised after the August 8, 2013 fall resulting in a fractured hip. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2013

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 16th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Chantal Lafrenière (194)

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

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