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

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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
Nov 20, 2013	2013_031194_0042	000869-13	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): November 5 & 6 , 2013

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse(RPN),Personal Support Worker(PSW), Activation Staff, Physician, Psycho Geriatric Consultant and four Residents

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents,licensee's policy on "Fall Prevention & Management","Least Restraint Policy"and"Pain and Symptom-Assessment and Management Policy". Observed staff to resident provision of care.

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

Minimizing of Restraining

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
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.)	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 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 :

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1. The licensee failed to comply with O. Reg 79/10 s. 49(2) when a post fall assessment was not completed for resident #1 post falls.

-The Licensee's policy "Falls Prevention and Management" VII-G-60.00 dated May 2013
directs the Registered staff post fall to complete the "falls incident report" (this is the licensee's clinically appropriate assessment instrument).

-on an identified date the progress notes state the resident is found sitting on the floor at the bedside with their wheelchair beside the bed. The progress notes state "staff reported that resident's lap belt was fastened at the time, buckled in the back of the wheelchair as usual, resident must have slid underneath belt."

-on an other identified date the progress notes state "the resident is found kneeling at the side of the bed."

There is no evidence that post fall assessments were completed on the two identified dates. [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, 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., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 110(1)1 when resident #1's seat belt was applied loosely and the resident was able to slide out of the device on two occasions resulting in falls.

-The licensee was not able to provide manufactures instruction for the application of the seat belt applied to resident #1.

-On an identified date the progress notes for resident #1 state "found on floor beside bed. No brakes on wheelchair and lap belt was done up. Appeared the resident had slid belt over head and unsuccessfully transferred to bed."

-On an other identified date the progress notes for resident #1 state the resident is found sitting on the floor at the bedside with wheelchair beside the bed. The progress notes state "staff reported that resident's lap belt was fastened at the time, buckled in the back of the wheelchair as usual, resident must have slid underneath belt."

-Resident #1 was observed during the inspection period sitting in a wheelchair. Resident #1 was able to pull the fastened seat belt forward with her hands and extend her arms in front of her while holding the seat belt. The seat belt was fastened in the back of the chair. The DOC was made aware of the seat belt application and lack of physician order for the seat belt and it was removed. [s. 110. (1) 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 staff apply physical devices in accordance with any manufacturers instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not comply with O. Reg 79/10 s. 134(a) when resident #1 was not monitored effectively for the risk level of the drug.

The physician was interviewed and confirmed that the daily limit for a resident for the medication "Tylenol" should not exceed 4000mg.

Resident #1 has a routine daily order for Tylenol of 4000 mg. On five separate incidents Registered staff administered PRN doses of Tylenol to resident #1 which exceeded the 4000mg total.

The only monitoring completed by staff related to the drug administered was a check mark in the back of the MARS indicating that the medication was effective for pain relief. [s. 134. (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 ensuring that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 31(2)4 when resident #1 did not have an order by the physician for the restraining device in place.

-During the inspection period resident #1 was observed sitting in their wheelchair with a seat belt restraint in place, fastened in the back of the chair. The resident was unable to unfasten the seat belt.

-Documentation for resident #1's restraint was being completed by the staff.

-Review of the physician's orders was completed and there was no evidence of a current order for the restraint for resident #1.

-Review of the current "Three Month Medication Review" was completed and there was no evidence of a current order for the restraint of resident #1.

The DOC was informed and the restraint was removed for resident #1. [s. 31. (2) 4.]

WN #5: 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 failed to comply with O. Reg 79/10 s. 52(2) when a pain assessment was not completed for resident #1 when PRN analgesic was administered on five separate incidents for complaint of pain.

Resident #1 has a routine order for Tylenol 1000mg four times a day. On five identified dates the progress notes state that the resident was complaining of pain and was administered PRN Tylenol.

The "Pain and Symptom - Assessment and Management Protocol" VII-G-70.00 dated May 2012 directs that;
Registered staff are to conduct and document a pain assessment:
-On initiation of a pain medication or PRN analgesic
-when report from resident, family staff/volunteers that pain is present.

Interview with RPN 1 and RN1 was completed and both staff stated that when a resident expressed a pain issue the Registered staff at the home, would make notes in the progress notes. RPN 1 stated that she would include the pain scale if able. The Registered staff stated that there was not a specific tool for pain assessment.

There is no evidence that resident #1 was assessed for pain when the PRN analgesic was administered when the resident was complaining of pain. [s. 52. (2)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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. (1)	CO #001	2013_031194_0032	194
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2013_031194_0032	194

Issued on this 20th day of November, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Chantal Lafrenière (194)