Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: July 4, 2024

Inspection Number: 2024-1524-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Haliburton Highlands Health Services Corporation

Long Term Care Home and City: Highland Wood, Haliburton

Lead Inspector	**Inspector Digital Signature**
Justin McAuliffe (000698)	Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2024.07.11 08:10:01 -04'00'

Additional Inspector(s)
Amanda Belanger (736)
Carole Ma (741725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24th to 27th, 2024

The following intake(s) were inspected:

- Intake related to a Proactive Compliance Inspection.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management

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Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Family Experience Survey

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee failed to ensure that a survey was taken of families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Summary and Rationale
The Director of Care (DOC) indicated that the home had not taken a survey of

families and caregivers related to their experience with the home and the care, services, programs and goods provided at the home.

There was no risk to the residents as a result of the lack of surveys for families and caregivers.

Sources: Interview with DOC. [736]

WRITTEN NOTIFICATION: Actions to Address Resident Survey

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (3)
Resident and Family/Caregiver Experience Survey
s. 43 (3) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly.

The licensee has failed to ensure that reasonable effort was taken to address concerns identified in the resident survey related to improvement of the home, and the care, services and programs provided.

Rationale and Summary
The results of the resident survey identified concerns related to meal service, laundry services, and staff members being available to assist when needed.

The DOC indicated that the home did not take steps to address the concerns identified in the resident survey.

There was minimal risk of harm to the residents by the home not actioning the

concerns brought forward.

Sources: Resident survey results; home's internal action plan; and, interview with the DOC. [736]

WRITTEN NOTIFICATION: Advice of Resident Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure that the advice of Residents' Council was sought out related to carrying out the resident experience survey.

Summary and Rationale
There was no indication in the Residents' Council meeting minutes that the resident experience survey had been discussed with the resident council for their advice, prior to the survey being implemented in the home.

The DOC indicated that they did not believe that it had been brought forward to Residents' Council.

There was risk, as the Residents' Council was not able to provide feedback prior to the survey being implemented.

Sources: Resident's Council Meeting Minutes; interview with the DOC. [736]

WRITTEN NOTIFICATION: Retraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that the required annual retraining was completed by all staff.

Rationale and Summary
During a review of the home's training records it was identified that multiple staff members had not completed annual retraining on infection prevention and control, the home's policy to promote zero tolerance of abuse and neglect of residents, and on the Residents' Bill of Rights.

In an interview with the director of care they confirmed the gap in annual retraining completion, and acknowledged the need to ensure all staff receive their required annual retraining moving forward.

Failing to ensure that staff completed their annual retraining, placed residents at low risk of harm.

Sources: Review of the homes annual training records; Interview with DOC.
[000698]

WRITTEN NOTIFICATION: Communication and Response System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (c)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(c) allows calls to be cancelled only at the point of activation;

The licensee has failed to ensure that the communication and response system only allowed calls to be cancelled at the point of activation.

Rationale and Summary
On two separate occasions during the inspection, staff were observed cancelling call bells from locations within the home that were not at the point of activation.

Both a PSW and an RPN indicated to the Inspector that call bells could be turned off at various locations within the home, not just at the point of activation.

The DOC acknowledged that during the inspection, the communication and response system was allowing calls to be cancelled from locations that were not at the point of activation.

There was risk of harm to all residents as a result of the call bell system being able to be cancelled at other places, other than the point of activation.

Sources: Inspector observations; license policy titled "Call Bell Response Policy", POL.LTC.24737; internal email communications; and interviews with staff. [736]

WRITTEN NOTIFICATION: Members of Quality Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that all required members of the Quality Committee were involved.

Summary and Rationale
A review of the home's terms of reference for the Quality Committee, as well as meeting minutes from the Resident Safety and Quality Committee had no indication

that a member from Residents' Council or Frailly Council attended; nor did they indicate that the Medical Director, Pharmacist, or Housekeeping and Maintenance Lead were attending and participating in the committee.

The DOC confirmed that not all required participates were involved in the home's Quality Committee at the home.

There was a risk, as not all members were participating and involved in the quality improvement within the home.

Sources: Resident Safety and Quality Improvement Meetings; Terms of Reference for the home's Quality Committee; Terms of Reference for the Corporate Quality Committee; and, interview with the DOC. [736]

WRITTEN NOTIFICATION: Continuous Quality Improvement Report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2)
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.
2. A written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative for the next fiscal year.
3. A written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for

quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.

4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

5. A written record of,

i. the date the survey required under section 43 of the Act was taken during the fiscal year,

ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

6. A written record of,

i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the Continuous Quality Improvement (CQI) Report had the required information.

Rationale and Summary
The DOC confirmed that the CQI report did not have the required information, including the name of the home's CQI lead listed, nor did the report have the date of the resident survey. The report did not contain the results of the resident survey, or the dates the results were shared with Residents and Family Council. The DOC confirmed that the CQI report also did not contain a written record of the actions the home had taken to improve the care and services based on the resident survey results.

There was no impact to the residents as a result of the CQI report not having the required information.

Sources: CQI report; and, interview with the DOC. [736]

WRITTEN NOTIFICATION: Additional Training

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

1) The licensee has failed to ensure that the required annual training on the homes pain management program and falls prevention and management program was completed by all staff.

Rationale and Summary
During record review of the homes training records, multiple staff members did not complete their annual pain management or falls prevention and management training.

In an interview with the director of care they confirmed the gap in annual training completion, and acknowledged the need to ensure all staff receive their required annual pain management and falls prevention and management training moving forward.

Failing to ensure that staff completed their annual training, placed residents at a low risk for harm.

Sources: Review of the homes annual training records; Interview with DOC. [000698]