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
Sep 10, 2013	2013_031194_0030	000024-13,000731-13	Complaint

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

HYLAND CREST
6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0

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 Complaint inspection.

This inspection was conducted on the following date(s): August 26 & 27, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC),Assistant Director of Care(ADOC), Dietitian, Physio Therapist (PT),Registered Nurse (RN), Personal Support Worker (PSW),and Resident

During the course of the inspection, the inspector(s) reviewed clinical health records for 6 residents, food and fluid intake records for resident #1, observed staff/resident provision of care and meal services on 2nd floor of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Nutrition and Hydration

Personal Support Services

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

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s.6(7)when the care set out in the plan of care for resident #1 was not provided as specified.

PSW #2 stated that staff try to get resident #1 up after breakfast, if the resident is resistive, staff will re-approach. PSW #2 stated that once the resident is up nourishment is provided.

The plan of care for resident #1 directs staff;
Mid morning breakfast will be given if the resident has slept through breakfast

On an identified day it was observed that resident #1 received only a drink from nourishment cart when the resident got up after breakfast. Resident #1 was not provided a mid morning breakfast as set out in the plan of care. [s. 6. (7)]

2. The licensee failed to comply with LTCHA ,2007 s.6(9)2 when the food and fluid intake for resident #1 was not documented.

Food and fluid intake records for a 6 week period was reviewed for resident #1. There were incomplete entries for 25 meals and 29 nourishment noted in the documentation reviewed.
[s. 6. (9)]

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 by ensuring that
- the care set up in the plan of care for resident #1 related to mid morning breakfast being provided as specified in the plan
- documentation of all food and fluid intake is documented for resident #1, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s.51(2)(a)(b) when resident #1 did not receive a continence assessment that included identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument. The plan of care for resident #1 was not individualized based on the assessment.

The DOC confirmed that the licensee's continence program, does provide an assessment that is to be completed for residents who are incontinent.

There was no evidence in the clinical health record for resident #1 that a continence assessment was completed.

The plan of care for resident #1 directs staff;
check for wetness ac, pc meals, qhs and on rounds during the night

The plan of care for resident #1 related continence was not based or individualized on a clinically appropriate assessment. [s. 51. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 73(2)(a) when PSW1 & PSW2 were observed assisting more than two residents who required total assistance with eating or drinking at the supper meal.

During the observation of the supper meal is was observed that PSW #2 was assisting 2 residents while assisting a third resident. PSW #5 was observed assisting 2 residents with eating while assisting a third resident. PSW #2 was also observed prompting and assisting (repositioning) residents at the table behind her.

The licensee failed to comply with O.Reg 73(2)(b) when resident #4, who requires total assistance with meals, was served the supper meal and not assisted by staff for 10 minutes after being served. [s. 73. (2)]

Issued on this 17th day of September, 2013

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

Chantal Lafrenière (194)