Ontario

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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 3, 2017	2017_640601_0005	004395-17	Resident Quality Inspection

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

KARYN WOOD (601), CAROLINE TOMPKINS (166), DENISE BROWN (626)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 20, 21, 22, 23, 27, 28, 29 and 30, 2017.

Critical incident Report (CIR) log #031110-16 related to allegations of staff to resident sexual abuse.

Critical incident Report (CIR) log #000348-17 related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Associate Director of Care, Dietary Manager, Cook, Dietary Aide, RAI-Coordinator, Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Life Enrichment Coordinator, Activity Aide, Housekeeping Aide, Maintenance Worker, Physiotherapist Assistant (PTA), Physiotherapist (PT), Family Council Co-Chair, Resident Council President, Residents and Families.

Also during the course of this inspection, the inspectors toured the home, observed meal service, medication administration, infection control practices, staff to resident interactions, and resident to resident interactions, reviewed resident clinical health records, Pharmacy and Therapeutic meeting minutes, the Family and Resident Councils meetings minutes, the Activation Program Calendar and the licensee's investigation documentation.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. related to log #031110-16

The licensee failed to ensure that the results of an abuse investigation were reported to the Director.

A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident sexual abuse.

Review of the CIR documentation indicated that resident #042 had reported to the Assistant Director of Care (ADOC) that on an identified date a staff member had inappropriately touched the resident during care, while another staff member stood by the resident's bedside and watched without saying anything.

Review of the licensee's investigation indicated that immediately upon resident #042 approaching the ADOC to report the alleged inappropriate touching, the licensee began the investigation.

Review of the licensee's investigation documentation indicated the investigation into the allegations of inappropriate touching of resident #042 by PSW #120 was not substantiated.

During an interview, the ADM/DOC indicated that the CIR was not amended to include the conclusion of the licensee's investigation into the allegations of staff to resident abuse. [s. 23. (2)]

Issued on this 3rd day of April, 2017

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

Original report signed by the inspector.