Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2021	2021_861194_0015	000182-21, 006837-21, 017028-21	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

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): November 1, 2, 3, 4, and 5, 2021

Inspected, Log #00182-21, Log #006837-21 and Log #017028-21 related to resident falls

During the course of the inspection, the inspector(s) spoke with Residents, Administrator/Director of Care (DOC), Infection Prevention and Control (IPAC) lead, COVID-19 Screener, Coroner, Housekeeper (HSK), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW)

During the course of the inspection, the Inspector, observed staff to resident provision of care, meal service, infection control practices and COVID-19 screening. The Inspector reviewed clinical health records of identified residents, air temperature records and reviewed staff and visitor COVID-19 screening and testing records, relevant policies related to hand hygiene and COVID-19 vaccination.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Légende 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 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 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.

A resident had an unwitnessed fall resulting in injury and required Head Injury Routine (HIR).

Review of the licensee's Management Program policy directed:
- Initiate a head injury routine if a head injury is suspected, if the resident fall is unwitnessed, or he/she is on anticoagulant therapy. Monitor HIR for 24 hours post fall for signs of neurological changes

Review of the Head Injury Routine (HIR) for resident post fall was completed and indicated that every 4 hours vital signs (V/S) were not completed as directed.

An RPN stated that the bed alarm was heard and the resident was found on the floor. The resident was assessed and HIR was initiated.

Another RPN confirmed that they vaguely remembered the incident, stating they cannot remember if HIR was completed. Failing to complete the clinically appropriate assessment instrument post fall can lead to underlying injuries being undetected, placing the resident at increased risk.

Sources: review of the clinical health records for resident, interview with staff . [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 by 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 LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to comply with the Minister's Directive: "COVID-19: Long-term care home surveillance testing and access to homes", effective July 16, 2021, when untested staff members entered the home.

The COVID-19 active screening and testing Triage Logs and the Panbio Testing records indicated during the reviewed period, 4 unvaccinated staff were able to enter the home to complete their shifts, without COVID-19 testing.

The DOC confirmed that unvaccinated or partially vaccinated staff were being required to test twice weekly, once with rapid antigen and once with PCR.

Interview with Screener confirmed that the staff had been screened but testing had not been completed. DOC confirmed that the staff had not been tested and follow up with the staff had been completed. Failing to ensure that unvaccinated staff were tested as Directed, increases the risk of spreading COVID-19 in the home.

Sources: COVID-19 screening and testing logs and staff interviews. [s. 174.1 (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 The licensee shall care out every operational or policy directive that applies to the long-term care home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the Infection Prevention and Control Program.

DOC confirmed that a hand hygiene program was in place at the home and that staff were required to provide hand hygiene to residents prior to and after meals. Review of the Hand Hygiene policy was completed and directed that staff were to perform hand hygiene before and after initial patient contact.

During meal services PSW's were observed assisting residents out of the dining area without providing hand hygiene. The PSW's confirmed that the staff were offering hand hygiene for a while but were no longer doing it consistently.

Inspector #194 observed a resident's semi-private room. A Personal Protective Equipment (PPE) hanger was in place but there were no gowns available, no additional precaution signage was in place and it was unclear for whom the additional precautions were to be used.

An RPN confirmed that the resident was under contact precautions. The RPN directed PSW staff to place appropriate signage and to stock appropriate PPE. The RPN confirmed that staff providing personal care would be required to wear, gown, gloves, and mask.

A PSW was observed leaving a resident ’s room with contact precaution signage. The PSW confirmed that they were assisting the resident with personal care. The PSW stated that they were aware of the PPE on the door and the additional precautions in place. The PSW stated they did not wear a gown as they did not touch the resident with their clothing, and when asked if they would change their mask they stated that it was not required.

Infection Prevention and Control (IPAC) lead was asked about PPE and signage for residents. IPAC lead confirmed that if the residents diagnosis were not active then there was no need for additional precautions to be in place for the resident and staff. Failing to ensure provide hand hygiene prior to and after meals, appropriate additional precaution signage are posted, PPE is available and that staff put on and take off PPE as directed increases the risk of spreading infection in the home.

Sources: observation of the meal service and IPAC practices, review of hand hygiene policy and interview with staff. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

Issued on this 11th day of December, 2021

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

Original report signed by the inspector.