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: April 26, 2023

Inspection Number: 2023-1478-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Haliburton Highlands Health Services Corporation

Long Term Care Home and City: Hyland Crest, Minden

Lead Inspector	**Inspector Digital Signature**
Tracy Muchmaker (690)	Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2023.04.28 13:46:40 -04'00'

Additional Inspector(s)
Samantha Fabiilli (000701)
Shannon Russell (692)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17- 21, 2023

The following intake(s) were inspected:

- One intake, which was a complaint related to the care of two residents;
- One intake, which was a follow up inspection related to CO #004 from inspection #2022_1478_0001, related to FLTCA, 2021 - s. 25 (1), for not complying with the home's policy to promote zero tolerance of abuse and neglect of residents;
- One intake, which was a follow up inspection related to CO #008 from inspection #2022_1478_0001, related to O. Reg. 79/10 - s. 114 (2) for not complying with the home's medication management policy related to transcription and administration of medications;
- One intake, which was a follow up inspection related to CO #001 from inspection #2022_1478_0001, related to O. Reg. 246/22 - s. 102 (2) (b), for failing to implement any standard or protocol issued by the Director with respect to infection prevention and control;
- One intake, which was a follow up inspection related to CO #002 from inspection #2022_1478_0001, related to O. Reg. 246/22 - s. 55 (2) (a) (ii), for not completing weekly skin and wound assessments;

- one intake, which was a follow up inspection related to CO #005 from inspection #2022_1478_0001, related to FLTCA, 2021 - s. 6 (10) (b), for not revising the plan of care when care needs changed;
- one intake, which was a follow up inspection related to CO #006 from inspection #2022_1478_0001, related to O. Reg. 246/22 - s. 54 (2), for not revising the plan of care related to falls prevention;
- One intake, which was a follow up inspection related to CO #003 from inspection #2022_1478_0001, related to O. Reg. 246/22 - s. 53 (2) (b), for not completing post fall assessments;
- One intake, which was a follow up inspection related to CO #007 from inspection #2022_1478_0001, related to O. Reg. 246/22 - s. 57 (2), for not completing pain assessments;
- One intake, which was a Critical Incident System report (CIS) related to the fall of a resident that resulted in a transfer to hospital and a significant change in status.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #004 from Inspection #2022-1478-0001 related to FLTCA, 2021, s. 25 (1) inspected by Tracy Muchmaker (690)

Order #008 from Inspection #2022-1478-0001 related to O. Reg. 79/10, s. 114 (2) inspected by Tracy Muchmaker (690)

Order #001 from Inspection #2022-1478-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Tracy Muchmaker (690)

Order #002 from Inspection #2022-1478-0001 related to O. Reg. 246/22, s. 55 (2) (a) (ii) inspected by Shannon Russell (692)

Order #005 from Inspection #2022-1478-0001 related to FLTCA, 2021, s. 6 (10) (b) inspected by Shannon Russell (692)

Order #006 from Inspection #2022-1478-0001 related to O. Reg. 246/22, s. 54 (2) inspected by Shannon Russell (692)

Order #003 from Inspection #2022-1478-0001 related to O. Reg. 246/22, s. 53 (2) (b) inspected by Shannon Russell (692)

Order #007 from Inspection #2022-1478-0001 related to O. Reg. 246/22, s. 57 (2) inspected by Shannon Russell (692)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's plan of care provided clear direction related to an identified activity of daily living (ADL).

Rationale and Summary:
A resident sustained a fall resulting in an injury, which lead to a change in status related to an identified ADL. The resident's care plan after return from hospital identified two conflicting interventions related to how staff were to assist the resident with the ADL.

A Personal Support Worker (PSW) and the DOC confirmed that there was a change in how staff were to assist the resident with the ADL, and which intervention was to be in place after the resident returned from the hospital. After reviewing the resident's care plan with the IDOC, they confirmed that they would not consider the care plan to be providing clear direction to staff with respect to the ADL.

Not having clear direction in the care plan resulted in low risk and no impact to the resident, as it was

determined that staff were providing the correct assistance for the ADL upon the resident's return from the hospital.

Sources: A resident's care plan; Interviews with a PSW, and the IDOC.
[000701]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 21.

The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment of the resident with respect to sleep patterns and preferences.

Rationale and Summary
A resident's plan of care did not include any information based on the resident's sleep patterns and preferences.

PSW and Registered staff verified that they would use the care plan or Point of Care (POC) to find information on a resident's care needs. A Registered Practical Nurse (RPN), and the IDOC, both verified that the plan of care did not include information on the resident's sleep patterns and preferences.

Not having information related to sleep patterns and preferences on the resident's care plan, presented a low risk to the resident. There was no impact on the resident, as staff were providing the care as per the resident's preferences.

Sources: A resident's plan of care; Interviews with a PSW , RPN, and the IDOC.
[690]