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: May 1, 2024
Inspection Number: 2024-1478-0001
Inspection Type: Complaint Critical Incident
Licensee: Haliburton Highlands Health Services Corporation
Long Term Care Home and City: Hyland Crest, Minden

Lead Inspector	**Inspector Digital Signature**
Sylvie Byrnes (627)	Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2024.05.07 13:48:29 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8 - 11, 2024.

The following intake(s) were inspected:

- One Critical Incident System (CIS) report related to improper/incompetent care of a resident;
- One CIS report related to an enteric outbreak in the home.; and,
- One complaint related to medication administration.

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matter to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director of Care (DOC), who had reasonable grounds to suspect that improper or incompetent care of a resident that resulted in harm or risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A resident's substitute decision maker (SDM) brought forth care concerns to the DOC, which were reported to the Director five days later. The DOC stated they had reported the incident to the Director after they had completed their investigation.

There was no harm caused to the resident from the late reporting to the Director.

Sources: interview with DOC; record review of a Critical Incident System (CIS) report and tip sheet for reporting (undated). [627]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

An enteric disease outbreak was declared in the home by the Public Health Unit (PHU) after multiple residents developed gastro-intestinal symptoms. The outbreak was reported to the Director 11 days after the outbreak was declared. The DOC stated they had waited to know the causative agent prior to reporting the outbreak to the Director.

There was low risk to the residents when the Director was notified late of the outbreak as all outbreak policies and protocols were put in place.

Sources: A CIS report, home's policy titled, "Critical Incident Reporting"; interviews with DOC and Infection, Prevention and Control (IPAC) lead. [627]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Develop and implement a process to clearly identify or flag specific situations within the medication administration system;
- Perform weekly audits to ensure that all applicable flags have been applied to the medication administration system for a minimum of one month, or longer if deficiencies are identified through the auditing process. Implement corrective action to address any deficiencies as required; and,
- Documentation of the audits and corrective actions, including the person completing the audits must be maintained.

Grounds

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was prescribed a medication to be administered at specific intervals to manage a chronic health condition; however, the medication was not administered as prescribed. The DOC acknowledged that the nurses had not completed all the necessary checks and that specific flags were not added to the medication administration record (MAR) system.

There was risk to the resident when they did not receive their medication as prescribed.

Sources: Interviews with resident's SDM, two RPNs, National Pharmacy Clinical Pharmacist and DOC; record review of investigation notes, Medication Administration Record (MAR) review, Home's policy titled, "Administrating Medications", a medication informational brochure.

[627]

This order must be complied with by

June 7, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.