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
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Original Public Report

Report Issue Date: August 16, 2024
Inspection Number: 2024-1478-0002
Inspection Type: Follow up
Licensee: Haliburton Highlands Health Services Corporation
Long Term Care Home and City: Hyland Crest, Minden

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 12-13, 2024

The following intake(s) were inspected:

- Intake: #00115158 - Follow-up #: 1 - O. Reg. 246/22 - s. 140 (2)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were closed:

Order #001 from Inspection #2024-1478-0001 related to O. Reg. 246/22, s. 140 (2).

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee did not ensure point-of-care signage for an identified resident indicated which enhanced IPAC control measures were in place, as is required by Additional Requirement 9.1 (e) under the IPAC Standard.

Rationale and Summary
A resident room was observed without point-of-care signage indicating enhanced IPAC measures were in place, however, personal protective equipment (PPE) was observed at the point-of-care.

The IPAC Lead confirmed point-of-care signage should have been in place as the resident was identified as requiring additional precautions.

The following day, the IPAC Lead informed the Inspector the signage had been posted. The Inspector observed that point-of-care signage indicating that enhanced IPAC measures were in place were posted to the room of the resident.

There was low risk when the licensee failed to ensure point-of-care signage indicating enhanced IPAC measures were in place for the identified resident.

Sources: Inspector observations; IPAC Standard for Long-Term Care Homes last reviewed: September 2023; and interviews with the IPAC Lead and other staff.

Date Remedy Implemented: August 13, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health was followed in the home.
Specifically, the licensee failed to ensure alcohol based hand rub (ABHR) used in the home was not expired as required by the Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

Rationale and Summary

It was observed that many of the hand-pump ABHR's in the home, including at the front entrance and in the resident dining areas, were expired.

The following day, the IPAC Lead indicated the expired ABHR throughout the home was replaced. Inspector observations on the same date reflected that the expired products had been changed out, and were not expired.

There was low risk when the licensee failed to ensure the ABHR in use in the home was not expired.

Sources: Inspector observations; Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024; and interview with the IPAC Lead.

Date Remedy Implemented: August 13, 2024