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

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Public Report

Report Issue Date: March 19, 2025

Inspection Number: 2025-1478-0002

Inspection Type:
Proactive Compliance Inspection

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): March 10-14, 2025.

The following intake(s) were inspected:

- Intake, related to a Proactive Compliance Inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain Management

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: FLTCA, 2021, s. 6 (7)

Plan of care s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was provided care as specified in their plan of care.

Specifically, the resident's plan of care indicated a specific intervention to be in place for a specified activity of daily living (ADL). However, the Inspector observed that the specific intervention was not implemented at the required times for the specific ADL.

Sources: Inspector observations; clinical records for a resident; and interviews with the resident, the Director of Care (DOC), and other staff.

The DOC consulted with the resident and updated the plan of care to reflect the specific intervention to be implemented at the required times.

Date Remedy Implemented: During inspection.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that when a resident's care needs changed, the plan of care was updated.

Specifically, the resident's plan of care indicated that they required a specified intervention implemented. However, a progress note indicated another intervention was in place due to a change with the resident. The plan of care was not updated when the change was implemented, and should have been.

Sources: Health file for a resident; and interviews with the resident, Personal Support Worker (PSW), and the DOC.

The resident's plan of care was updated to reflect their current care needs.

Date Remedy Implemented: During inspection.

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (1)

Resident and Family/Caregiver Experience Survey s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the

residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee has failed to ensure that at least once in every year, a survey was taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Specifically, the home did not survey families and caregivers on their experience within the past year. The Administrator acknowledged that only the resident's were surveyed.

Sources: Review of the Resident Satisfaction Survey; email titled "Resident Survey" sent by the Administrator; and interview with the Administrator.

WRITTEN NOTIFICATION: Retraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that staff completed annual retraining for Infection Prevention and Control (IPAC) practices. Two direct care staff's training records for the previous year, and to present, did not include that they had completed re-training for IPAC practices, including the specific topics required.

Sources: Training records for two direct care staff members; Inspectors observations; and interviews with staff members. the IPAC Lead, the DOC and Administrator.

WRITTEN NOTIFICATION: General Requirement

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

General requirements s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the annual evaluation of the home's Skin and Wound Management Program and Pain Management Program were completed in full.

The annual program evaluation for the Skin and Wound Management and Pain Management programs had identified strategies for improvement; however, had not included a summary of changes, and the dates changes had been implemented.

Sources: the LTCHs Skin and Wound Management Program annual evaluation; the pain management program evaluation; and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 35 (3) (e)

Nursing and personal support services

s. 35 (3) The staffing plan must, (e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure that the Nursing and Personal Support Services program was evaluated annually. The Administrator and DOC identified that they did not

complete an annual review of the program at any time in the past year.

Sources: The homes Staffing Plan for the Nursing and Personal Support Services; and interviews with the DOC and Administrator.

WRITTEN NOTIFICATION: Skin and Wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care s. 55 (2) Every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's wound was assessed by a registered staff at least weekly. The resident's wound had not been assessed at least weekly on two occasions.

Sources: A resident's health care records; Inspector observations of the resident; the home's policy titled, "Skin and Wound Care Management Program", #POL.LTC.28586, last approved 05/10/2024; and interviews with registered staff, and the DOC.

WRITTEN NOTIFICATION: Medication management system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 125 (1)

Annual evaluation

s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend

any changes necessary to improve the system.

The licensee failed to ensure that the annual medication management program evaluation included the registered dietitian (RD).

Sources: The medication management program evaluation dated; and an Interview with DOC.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2)

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the continuous quality improvement (CQI)

committee was composed of the required persons.

Specifically, the quality committee was comprised for the Haliburton Highlands Health Services (HHHS) as a whole, with the LTC having part in the meetings. However, the meetings for the home did not achieve all of the responsibilities of the quality improvement committee as detailed under O. Reg 246/22 s. 166 (3).

The quality committee meetings for the HHHS did not include the home's medical director, the designated leads of the home, the home's RD, the home's pharmacy service provider, a registered staff member of the home, a PSW who provides personal support services in the home, and one member of the home's Residents' and Family Council.

Sources: Review of meeting minutes for Resident Safety Meetings and the Haliburton Highlands Health Services Quality Committee; and interview with the Administrator.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall

publish a copy of each report on its website.

The licensee has failed to ensure that a report on the CQI initiative for the home was prepared for each fiscal year and failed to ensure a published copy of each report was on their website.

The Administrator indicated the home did not prepare a CQI initiative report specific to the home, rather it was done under the umbrella of the HHHS. Additionally, the home did not publish a copy of their report on their website for each fiscal year.

Sources: Inspector observation of the home's website; review of the published report titled "Continuous Quality Improvement Report", review of the report titled "QIP for Haliburton Highlands Health Services"; and interview with the Administrator.