Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: August 10, 2023	
Inspection Number: 2023-1152-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Haliburton, Haliburton	
Lead Inspector Steven Naccarato (744)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-12, 2023.

The following intakes were inspected:

- One intake was regarding a complaint related to the management of responsive behaviours of a resident.
- One intake was regarding the responsive behaviours of a resident.

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

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Medical Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 78 (1)

The licensee has failed to ensure that the home had a Medical Director.

Rationale and Summary

In an interview with the Administrator, they stated that the home has not had a Medical Director since 2021 and despite multiple attempts, the home has not succeeded in employing a qualified replacement.

The home not having a Medical Director was low risk to residents.

Sources: A critical incident; Interviews with the Administrator and other staff.

This Written Notification is being referred to the Director for further action by the Director.

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate in the resident's discharge planning.

Rationale and Summary

In an interview with the Director of Care (DOC), they stated that the SDM had not been included in the resident's discharge planning.

The home not involving the family in the discharge planning was low risk to the resident.

Sources: The resident's electronic health care records; and an interview with the DOC.
[744]