Ontario

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

Ministry of Long-Term Care
Long-Term Care Compliance Branch

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Original Public Report

Report Issue Date: November 4, 2022	
Inspection Number: 2022-1524-0001	
Inspection Type: Complaint	
Licensee: Haliburton Highlands Health Services Corporation	
Long Term Care Home and City: Highland Wood, Haliburton	
Lead Inspector Lynda Brown (111)	**Inspector Digital Signature**
Additional Inspector(s) Holly Wilson (741755)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 17 to 19, 2022

The following intake(s) were inspected:
-Complaint Log #008588 related to discharges, resident charges and plan of care.

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

Infection Prevention and Control
Food, Nutrition and Hydration
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Admission, Absences and Discharge
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure that prescribed treatment creams for two residents were kept secured and locked.

During a tour of the home, a treatment cream was observed in a specified area belonging to a resident. There were additional treatment creams observed in the same resident's room that were not secured or locked. Observation of another resident's room indicated there were treatment creams that were not secured or locked. An RPN indicated both residents kept their prescribed treatment creams in an area that was not locked.

Failing to ensure prescribed treatment creams are kept secured and locked when not in use, may result in other residents having access them.

Sources: observations, interviews of residents and interview of staff.
[111]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)

The licensee failed to ensure that identified residents did not administer a drug to themself unless the administration had been approved by the prescriber in consultation with the resident.

Observations of specified areas indicated there were identified residents with prescribed treatment creams that were not stored in a secured area. An RPN indicated both identified residents self-administered the treatment creams and were stored in a specified area. The DOC confirmed the expectation was for the Registered staff to obtain a physician's order and complete the self-medication resident evaluation form for any residents who self-administered treatment creams. The identified residents had no physician order in place that indicated the residents could self-administer the treatment creams or keep them stored at a

specified location.

Failing to ensure that residents do not administer treatment creams to themself unless they have been approved by the prescriber lead to prescribed treatment creams being left in unsecured areas.

Sources: observations and review of health records of a number of residents, and interview of staff.
[111]

WRITTEN NOTIFICATION: Plan of Care, Involvement of resident etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute decision-maker, designated by the resident, was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to medication changes.

A complaint was received by the Director from the Substitute Decision Maker (SDM) of a resident regarding the SDM not being informed of medication changes. On specified dates, the resident had changes to their specified medications. Both the DOC and an RPN both confirmed the Registered staff were to notify the SDM of any changes in medications and document in the residents' progress notes. There was no documented evidence the SDM was notified of the identified medication changes in the progress notes.

Failing to notify the SDM of a resident's medication changes does not allow the SDM an opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: clinical records for a resident and interviews with staff.
[741755]

WRITTEN NOTIFICATION: Laundry Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)

The licensee has failed to ensure their process to report and locate residents' lost clothing was complied with for a resident.

A complaint was received by the Director from the Substitute Decision Maker (SDM) of a resident regarding several items of missing clothing. An RPN confirmed awareness of the resident having several missing clothing items and did not complete the missing clothing form as required. The DOC confirmed the home had a policy to address missing resident laundry and the policy had not been followed. The DOC indicated the home had located some of the missing clothing items as a result of the inspection.

Failure to comply with the process to report and locate residents' lost clothing resulted in a resident having less clothing items.

Sources: Missing Laundry Policy, progress notes for a resident and staff interviews.
[741755]