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: July 14, 2023	
Inspection Number: 2023-1524-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Haliburton Highlands Health Services Corporation	
Long Term Care Home and City: Highland Wood, Haliburton	
Lead Inspector Sylvie Byrnes (627)	**Inspector Digital Signature** Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2023.07.14 14:24:05 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4-6, 2023

The following intake(s) were inspected:
- One Intake related to a fall; and,
- One complaint related to care concerns of a resident.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment and care of a resident that resulted in harm had occurred, reported the

suspicions 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 for a resident to a Registered Practical Nurse (RPN) and the Director of Care (DOC). The concerns were not reported to the Director. The DOC stated that they had not reported the concern to the Director as they felt the issue had been dealt with and that the SDM was satisfied with the outcome.

Sources: Interviews a resident's SDM, RPNs and DOC; Record review of progress notes, home's policy titled, "Zero Tolerance of Abuse and Neglect Policy". [627]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.

The licensee has failed to ensure the plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's health condition.

Rationale and Summary

A resident developed symptoms of illness on a specific date. The physician was only called on the following day. The DOC stated that the physician should have been called immediately when the resident developed symptoms of illness.

Sources: Interview with SDM, DOC and other staff members, record review of progress notes, Advance Directives for Long-Term Care admission package, Ontario Laboratories information System Lab Data report. [627]