

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

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

Public Report

Report Issue Date: October 21, 2025

Inspection Number: 2025-1478-0004

Inspection Type:

Critical Incident
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): October 6-10, 2025.

The following intake(s) were inspected:

- One intake related to follow up to compliance order (CO) for bed entrapment;
- Two intakes related to follow up for COs regarding the Skin and Wound program;
- Two intakes regarding follow up for COs related to Medication administration;
- One intake regarding an incident of resident-to-resident physical abuse; and,
- One intake related to a fall of a resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2025-1478-0003 related to O. Reg. 246/22, s. 18 (1)

Order #003 from Inspection #2025-1478-0003 related to O. Reg. 246/22, s. 55 (2) (b) (iv)

Order #001 from Inspection #2025-1478-0003 related to O. Reg. 246/22, s. 55 (2) (b) (ii)

Order #005 from Inspection #2025-1478-0003 related to O. Reg. 246/22, s. 147 (1) (a)

Order #004 from Inspection #2025-1478-0003 related to O. Reg. 246/22, s. 140 (2)

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

Skin and Wound Prevention and Management
Medication Management

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Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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 (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;
or

The licensee has failed to ensure that a resident's plan of care was revised when there had been a change in the care that they required.

Sources: Critical Incident (CI) report; a resident's health care records; Inspector's observations; and interviews with direct care and registered staff, the Director of Care (DOC) and the Administrator.

Date Remedy Implemented: October 7, 2025

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-

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maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision maker (SDM) was notified of an incident that involved them.

Sources: CI report; a resident's health care records; the homes internal investigation notes; and interviews with direct care and registered staff, the DOC and the Administrator.

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident had exhibited responsive behaviours towards another resident, that the interventions were implemented and documented.

Sources: CI report; a resident's health care records; the homes internal investigation notes; and interviews with direct care and registered staff, the DOC and the Administrator.