Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 3, 2015 | 2015_299559_0011 | T-4261-15 | Critical Incident System |

### Licensee/Titulaire de permis

HILLCREST VILLAGE INC.
255 RUSSELL STREET MIDLAND ON L4R 5L6

### Long-Term Care Home/Foyer de soins de longue durée

HILLCREST VILLAGE CARE CENTRE
255 RUSSELL STREET MIDLAND ON L4R 5L6

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANN HENDERSON (559)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): May 11, 2015.**

**During the course of the inspection, the inspector(s) spoke with administrator, director of resident care (DRC), nursing administration support co-ordinator and registered staff.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On March 13, 2015, the licensee submitted a critical incident form to the ministry of health.
Record review and staff interviews revealed two residents narcotic medications prescribed for 8 p.m., had been administered by 3 p.m.and this was discovered by the home during a routine audit of the medications.

The RN that was conducting that audit also discovered five residents had received their regular 8 p.m. medications by 3 p.m., and on a second identified home area eight residents had also received their regular 8 p.m., medications by 3 p.m. In the medication room it was further identified there were two sealed medication pouches containing medications discarded in the garbage. The identified RPN had signed off the medication records for two residents as having given the medications that were discarded on an identified date.

An interview with the DRC revealed, it is the expectation when a nurse administers medications; the nurse follows the medication practice standard as per the College of Nurses and the home's policy.

The DRC confirmed the RPN failed to administer prescribed drugs at the correct time to seventeen residents. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of the home's policy 8-1 Medication Administration Record (MAR) under the section for documentation and record keeping, instructs staff to document all medications administered, not administered, or refused by a resident.

On an identified date at 3 p.m., during a routine audit of medications an RN discovered two residents had received narcotics earlier than prescribed, thirteen residents had received their 8 p.m. medications earlier than prescribed, one resident's medications were being held as the RPN had stated it was easier to give them four hours late. Two residents failed to receive their medications on an identified date.

Staff interviews revealed the electronic MAR accurately records when a resident receives a medication. MAR records for the residents revealed electronic signatures were missing.

An interview with the DRC confirmed the RPN failed to follow the home's policy for medication administration. [s. 8. (1) (b)]

**Issued on this 11th day of June, 2015**

**Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs**

**Original report signed by the inspector.**