

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

Original Public Report

Report Issue Date: March 28, 2024	
Inspection Number: 2024-1313-0001	
Inspection Type: Critical Incident	
Licensee: Hillcrest Village Inc.	
Long Term Care Home and City: Hillcrest Village Care Centre, Midland	
Lead Inspector Loviriza Caluza (687)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18 to 22, 2024

The following intake(s) were inspected:

- One intake related to COVID-19 outbreak, and
- One intake related to improper/incompetent care of a resident.

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

- Medication Management
- Infection Prevention and Control

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The home has failed to ensure that no drug was administered to a resident unless it was prescribed.

Rationale and Summary

Review of the home's documents related to the incident indicated that a registered staff had administered a medication not prescribed to a resident.

The Director of Care (DOC) acknowledged that a registered staff had administered a medication not prescribed to a resident as they failed to confirm the identity of the resident.

Failure to correctly identify a resident prior to administering a medication had placed a resident at risk for their health and well-being. However, the impact was low as the home had intervened immediately.

Sources: CIS report; observation, record reviews, and interview with staff members



**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

159 Cedar St, Suite 403

Sudbury, ON, P3E 6A5

Telephone: (800) 663-6965

and the DOC.

[687]



**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

159 Cedar St, Suite 403

Sudbury, ON, P3E 6A5

Telephone: (800) 663-6965