Ontario

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

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

London District
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Original Public Report

Report Issue Date: February 9, 2024	
Inspection Number: 2024-1560-0001	
Inspection Type: Critical Incident	
Licensee: Corporation of the County of Huron	
Long Term Care Home and City: Huronview Home for the Aged, Clinton	
Lead Inspector Debbie Warpula (577)	**Inspector Digital Signature**
Additional Inspector(s) Loma Puckerin (705241)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7 and 8, 2024

The following intake(s) was inspected:

- Intake: #00102144 - M541-000028-23 related to improper medication administration

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with CareRx medication policies related to medication administration included in the required Medication Management Program.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee is required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, an RPN did not comply with CareRx policy “The Medication Pass" revised June 30, 2023.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director regarding

improper medication administration.

Review of CareRx policy “The Medication Pass" revised June 30, 2023, indicated that staff were required to ensure that the resident was ready to take the medication and observe the resident to ensure the medication has been swallowed.

During an interview with a Registered Practical Nurse (RPN) they advised that they administered an oral medication in a specific texture by mouth. Advised that they had not checked the resident’s mouth to have ensured whether the resident had swallowed the medication and they assumed the resident swallowed the medication.

In an interview with a Registered Nurse (RN), they advised that a Personal Support Worker (PSW) reported that they found oral medication in the resident’s mouth, administered by an RPN. The RN stated that they removed the medication from the resident’s mouth.

During an interview with the Director of Care (DOC), they advised that there was a risk of harm to the resident and the RPN should have assessed the resident first and held the oral medication.

There was risk of harm to the resident when the home’s medication policy was not complied with by a staff member.

Sources: Critical Incident (CIS) System report, medication incident report, personnel file, CareRx policy "The Medication Pass", investigation records, and interviews with an RN, an RPN and the DOC.

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