

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007****Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée****Long-Term Care Operations Division  
Long-Term Care Inspections Branch****Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**Central East Service Area Office  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 9, 2020	2020_815623_0018	018166-20	Complaint

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**Licensee/Titulaire de permis**Haliburton Highlands Health Services Corporation  
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0**Long-Term Care Home/Foyer de soins de longue durée**Hyland Crest  
6 McPherson Street P.O. Box 30 Minden ON K0M 2K0**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

SARAH GILLIS (623)

**Inspection Summary/Résumé de l'inspection****The purpose of this inspection was to conduct a Complaint inspection.****This inspection was conducted on the following date(s): October 7-9, 13, 2020****The following intakes were inspected:  
A complaint related to medication incidents.****During the course of the inspection, the inspector(s) spoke with The  
Administrator/Director of Care, Registered Nurses (RN), Registered Practical  
Nurses (RPN)****The following Inspection Protocols were used during this inspection:**

**Medication**

**During the course of this inspection, Non-Compliances were issued.**

- 1 WN(s)**
- 1 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**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 were administered to resident #002 in accordance with the directions for use by the prescriber.

A complaint was received by the Director alleging that resident #002 had received a double dose of a prescribed medication.

Medication incident reports for resident #002 were reviewed, along with physician orders, Medication Administration Records (eMAR), narcotic count sheets, progress notes, and assessments.

During a controlled substance medication count it was discovered that on a specified date and time, RN #103 administered a specific medication, to resident #002, when a different dose was ordered. The order had been changed from as needed to routine.

The Administrator/Director of Care (Admin/DOC) confirmed that on a specified date, resident #002 did not receive a specific medication in accordance with the Directions for use by the prescriber.

The licensee failed to ensure that medications were administered to resident #002 in accordance with the directions for use by the prescriber.

Sources: Medication incident report, eMAR, narcotic count records, physician orders, interview with Admin/DOC. [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 by ensuring 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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Issued on this 18th day of November, 2020

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

**Original report signed by the inspector.**