Ontario

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 28, 2024
Inspection Number: 2024-1554-0002
Inspection Type: Critical Incident Follow up
Licensee: The Corporation of Haldimand County
Long Term Care Home and City: Grandview Lodge / Dunnville, Dunnville

Lead Inspector	**Inspector Digital Signature**
Indiana Dixon (000767)	Indiana A Dixon Digitally signed by Indiana A Dixon Date: 2024.07.03 10:42:48 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): May 29, 30, 31, 2024

The following intake (s) were inspected:

- Intake: #00104360 – [Critical Incident (CI): M532-000042-23] related to Medication Management.
- Intake: #00111387 - Follow-up #: 1 - CO #001 / 2024-1554-0001, O. Reg. 246/22 - s. 102 (2) (b), IPAC, CDD May 24, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1554-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Indiana Dixon (000767)

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

Medication Management
Infection Prevention and Control
Staffing, Training and Care Standards

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 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident did not receive their medication on two specified dates.

Staff confirmed that the resident missed their medication, as their order was not processed as required.

Sources: Medication Administration Records, Critical Incident Report, interviews with staff.

[000767].