

**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**

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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>
Oct 21, 2021	2021_927957_0003	011751-21	Critical Incident System

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**Licensee/Titulaire de permis**

Meadow Park (Chatham) Inc.  
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Meadow Park Nursing Home (Chatham)  
110 Sandys Street Chatham ON N7L 4X3

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

CATHERINE OCHNIK (704957), ALI NASSER (523)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): October 19, 2021.**

**This inspection was completed for a Critical Incident inspection related to a medication incident.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), a Registered Nurse (RN), a Housekeeping staff member and a resident.**

**During the course of the inspection the inspectors toured the home, observed residents and medication administration, reviewed clinical records, relevant home policies and procedures, and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:  
Infection Prevention and Control  
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>

**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 a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

A Critical Incident System (CIS) report indicated that a medication error involving a resident occurred during a medication pass. A registered staff member gave a resident the incorrect medication.

Clinical record review showed that the registered staff member administered medication not as prescribed.

During an interview, the Director of Care said that a medication error involving a resident had occurred when a registered staff member did not administer the drug as prescribed.

Sources: CIS report, resident clinical record review, interview with staff. [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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**Issued on this 21st day of October, 2021**

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

**Original report signed by the inspector.**