

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

Public Report

Report Issue Date: November 24, 2025

Inspection Number: 2025-1329-0005

Inspection Type:

Complaint
Critical Incident

Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

Long Term Care Home and City: The Meadows, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 3, 4, 5, 6, 13, 14, 17, 18, 19 and 24, 2025, and offsite on November 20, 2025.

The following intakes were inspected:

#00160655 - Critical Incident System (CIS) report 2844-000038-25, related to improper/incompetent treatment of a resident.

#00160821 - complaint 2025-0004199, related to duty to protect, administration of drugs, and dining and snack service.

#00161711 - CIS report 2844-000041-25, related to duty to protect.

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

- Medication Management
- Food, Nutrition and Hydration
- Prevention of Abuse and Neglect
- Residents' Rights and Choices

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

a) A resident was prescribed a medication with instructions for use based on assessment values. The dosage of the medication to be administered was unclear for a specific assessment value. Additionally, the directions in the electronic Medication Administration Record (eMAR) for the administration of the medication was not consistent with the directions in the order related to a specific assessment value.

b) A resident was ordered a medication at bedtime. The eMAR initially included directions for administration which were not consistent with the order.

c) The prescriber's order to administer a resident's medication with meals was identified on the eMAR to be administered before meals.

Sources: Review of a resident's eMAR, progress notes and Prescriber's Digijorders and interviews with multiple staff.

WRITTEN NOTIFICATION: General Requirements

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NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

- a) A specific assessment finding for a resident was not documented on more than five occasions over a seven week time period.
- b) Assessments of a resident and the decision to hold a medication on two occasions were not documented.
- c) Following an assessment of a new medication order the prescriber was contacted by staff for clarification, prior to the order being processed. The discussion with the prescriber, the following day, nor the clarification was documented.

Sources: Review of eMAR, progress notes, Prescriber's Digiorde records, relevant sections of vital signs report, an Algorithm, and interviews with staff.

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

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In accordance with O Reg 246/22 s. 11 (1) b, the licensee was required to ensure that identified procedures were complied with.

Specifically, staff did not comply with their procedures when: they did not enter orders in the eMAR for medications administered prior to the pharmacy delivery including stat doses; they did not initial on the eMAR for each medication; new orders were not entered into the eMAR by the next administration time for dosage changes, when the medication was available; nursing staff did not enter all non drug related orders into Point Click Care (PCC); and the Prescriber's Order Form was not used as the primary means of placing all new orders.

- a) A resident's stat orders and or changes in direction for a medication were not entered onto the eMAR, by nursing, before the next scheduled administration time, to allow staff to document their initials on approximately 10 occasions over six weeks.
- b) Changes to a resident's prescribed intervention were not included into the eMAR for administration until three days later.
- c) A medication was administered to a resident; however, not initialled on the eMAR, on at least two occasions when the dates and times were crossed off on the eMAR.
- d) A medication was given on two occasions from the emergency drug box; however, not entered onto the eMAR by nursing staff or initialled.
- e) A medication was given the day after it was ordered, despite availability in the emergency drug box and the order was not entered into the eMAR when it was first received.
- f) Stat orders for a medication were not entered into or signed for on the eMAR on three occasions.
- g) A resident was prescribed a specialized diet; however, the order was not entered into into the eMAR nor into PCC as a referral to the RD.
- h) When a medication was prescribed for a resident for five days, staff did not enter into the eMAR the requirement for supplemental documentation, specifically to

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record the dosage of the medication administered.

i) Progress notes included the plan to change a prescribed intervention for a resident; however, this was not documented on the Prescriber's Order Form.

Sources: Review of Policies and Procedures: Manual for MediSystem Serviced Homes, Digi-order Prescribing, Medication Administration, Change in Dose and PCC Integration Medication Management (IMM) Order Processing Procedures; review of a resident's progress notes, Prescriber's Digiorder, and eMAR, and interviews with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 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).

a) A resident was ordered a medication to be taken for a limited number of dosages. The resident received two additional dosages of the medication.

b) A resident was administered a medication on eight occasions over the span of 16 days which was not consistent with the directions.

Sources: A review of the Prescriber's Digiorder, eMAR, progress notes for a resident and interviews with multiple staff.