



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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## **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Aug 19, 2016	2016_323130_0014	025170-16	Complaint

### **Licensee/Titulaire de permis**

THE REGIONAL MUNICIPALITY OF NIAGARA  
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

THE MEADOWS OF DORCHESTER  
6623 Kalar Road NIAGARA FALLS ON L2H 2T3

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

GILLIAN TRACEY (130)

## **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): August 17 and 18, 2016.**

**Please note this inspection is linked to the following CI inspection: 024552-16.  
During this inspection medication was observed, clinical records, incident reports  
and relevant policies and procedures were reviewed.**

**During the course of the inspection, the inspector(s) spoke with the Director of  
Resident Care (DRC), Physician and registered staff.**

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



## Medication

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

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

### NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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



**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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) On an identified date in 2016, at approximately 1200 hours, a verbal physician's order was obtained for resident #001, by registered staff #005 and #006, which directed staff to administer a specified dose of medication stat. The same medication was also ordered to be given routinely before a specific treatment was performed.

On the same date in 2016, at approximately 1215 hours, registered staff #004, with registered staff #005 present, administered the incorrect dose of medication to the resident.

Interviews with staff #004, the DRC and incident reports reviewed, confirmed resident #001 was administered the incorrect dose of medication.

Resident #001 did not receive medication in accordance with the directions for use specified by the prescriber. (Inspector #130). [s. 131. (2)]

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**Issued on this 19th day of August, 2016**

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

**Original report signed by the inspector.**