

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: November 4, 2024

Inspection Number: 2024-1101-0006

Inspection Type:Critical Incident

Licensee: 955464 Ontario Limited

Long Term Care Home and City: Crescent Park Lodge, Fort Erie

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): October 28, 29, 30, 2024

The following intake (s) were inspected:

- Intake: #00112585 [Critical Incident (CI): 2587-000008-24] related to Medication Management.
- Intake: #00126029 [CI: 2587-000017-24] related to Prevention of Abuse and Neglect.

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

Medication Management Infection Prevention and Control Prevention of Abuse and Neglect

INSPECTION RESULTS



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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 prescribed by the prescriber.

Rationale and Summary

A resident's clinical records as well as the home's internal investigation showed that a resident did not receive their medication on a specified date. This was also confirmed by members of the home's staffing team.

Sources: A resident's Medication Administration Records, internal investigation notes, Medication Incident Report, and staff interviews.