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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: November 1, 2023	
Inspection Number: 2023-1574-0002	
Inspection Type: Critical Incident	
Licensee: Board of Management of the District of Kenora	
Long Term Care Home and City: Pinecrest (Kenora), Kenora	
Lead Inspector Christopher Amonson (721027)	**Inspector Digital Signature** Christopher E Amonson Digitally signed by Christopher E Amonson Date: 2023.11.06 14:40:23 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26 - 28, 2023
The inspection occurred offsite on the following date(s): September 29, 2023

The following intake(s) were inspected:

- Two intakes related to falls; and
- One intake related to alleged abuse of resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that for a resident demonstrating responsive behaviours, the resident's responses to interventions were documented.

Rationale and Summary
A registered staff member submitted a late entry progress note for an incident that had occurred previously, where staff implemented interventions to ensure the safety of both the resident and staff during the provision of care. The resident was observed to have altered skin integrity following this interaction with staff.

The Director of Care (DOC) confirmed that the registered staff wrote a progress note that was considered late documentation. At the time of the incident, the resident's care plan listed interventions that required staff to monitor and document the resident's moods and behaviours.

With the failure to document in a timely manner, communication related to this interaction, including interventions used to manage the resident's responsive behaviours, was unavailable.

Sources: Critical incident report; resident health records; the home's investigation file; and interviews with DOC and staff. [721027]