

**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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2020	2019_773155_0020	019098-19, 022073- 19, 022111-19, 023296-19, 023478-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Pinecrest Manor
399 Bob Street P.O. BOX 220 LUCKNOW ON N0G 2H0

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

SHARON PERRY (155)

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): December 11,16, 17, 2019, January 2 and 3, 2020.

Sarah Inglis, Inspector #767 was also present during this inspection.

The following intakes were completed within this complaint inspection:

Log 019098-19 related to medication administration;

Log 022073-19, Log 022111-19, and Log 023478-19 related to qualifications of staff and

Log 023296-19 related to alleged staff to resident abuse, sufficient staffing, and availability of hot water for dishwasher.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Recreation Manager, Education/Nursing Coordinator, Assistant Director of Care/Resident Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspectors also toured resident living areas; reviewed relevant clinical records, schedules, job descriptions, employee files and relevant investigation notes; observed medication administration, and observed resident and staff interactions.

The following Inspection Protocols were used during this inspection:

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

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

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Légende

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).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 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.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long Term Care received a complaint that resident #001 did not receive their medication as ordered.

Resident #001's physician's orders included that they were to receive a medication by mouth three times a day. The specific medication administration record directed that the medication was to be given at three different times during the day. On an identified date, registered staff did not administer the medication at one of the times and it was given approximately two hours later.

Review of an identified requisition for resident #001 did not include any direction that resident #001 could not take medications. Director of Care #112 shared that physician orders were to be obtained prior to holding medications related to identified appointments and there were not orders obtained for resident #001.

The licensee failed to ensure that resident #001 was given their medication at an identified time on a specific date as per their plan of care. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of January, 2020

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

Original report signed by the inspector.