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

Central West District
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Public Report

Report Issue Date: January 17, 2025

Inspection Number: 2024-1112-0009

Inspection Type:
Complaint

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Pinecrest Manor, Lucknow

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6, 7, 9 and 14-16, 2025.
The inspection occurred offsite on the following date(s): January 8, 2025
The following intake(s) were inspected:

- Intake: #00130723, complaint related to the care of residents.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that two residents had their rights individuality respected when staff were providing care to them and had conversations in a language they could not understand. As well as one resident hearing staff conflicts within the home.

As a result of the staff not respecting the resident's individuality, the two residents felt uncomfortable impacting their personal care and one resident felt upset.

Sources: Interviews with three residents, a PSW, the Director of Care and the Executive Director.

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WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward written complaints to the Director.

A) A written complaints sent to the Director of Care (DOC) related to alleged physical abuse.

Sources: Emails, interviews with the DOC and ED.

B) A written complaint sent to the Director of Care (DOC), related to alleged neglect.

Sources: Emails, interviews with the DOC and ED.

C) A written complaint sent to the Director of Care (DOC), related to improper care of a resident.
Sources: Emails, interviews with the DOC and ED.
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WRITTEN NOTIFICATION: Licensee Must Investigate, Respond And Act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that when the Director of Care (DOC) received a written complaint related to alleged physical abuse of a resident by a Personal Support Worker (PSW), it was immediately investigated.

Sources: Email complaint, interviews with the DOC and the Executive Director.

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WRITTEN NOTIFICATION: Licensee Must Investigate, Respond And Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(ii) neglect of a resident by the licensee or staff.

The licensee has failed to ensure that when the Director of Care (DOC) received a written complaint it was immediately investigated.

A) Email related to alleged neglect of residents by a Personal Support Worker (PSW).

Sources: Email, interviews with the DOC and Executive Director.

B) When a PSW reported to a Registered Nurse alleged neglect of a resident.

Sources: Email, interviews with the DOC and Executive Director.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure to immediately report suspicion of improper care of a resident to the Director when the Director of Care (DOC) received a written complaint.

Sources: Email, interviews with a PSW, the DOC and the Executive Director.
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WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure to immediately report suspicion of physical abuse when the Director of Care (DOC) received a written complaint.

A) The DOC received a written complaint related to alleged physical abuse of a resident by a Personal Support Worker.

Sources: Email, interviews with DOC and Executive Director.

B) The DOC received a written complaint related to alleged neglect of two residents by a PSW.

Sources: Email, interviews with DOC and Executive Director.

C) When a PSW reported to a Registered Nurse alleged neglect of a resident.

Sources: Email, interviews with DOC and Executive Director.

WRITTEN NOTIFICATION: Infection Prevention And Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

IPAC Standard for LTCHs dated April 2022, revised September 2023, section 4.1 b), stated that the licensee shall ensure that the outbreak management system includes: Outbreak management policies, procedures, and protocols implemented.

The licensee has failed to ensure that there was a cohort of residents to their specific wings as per their public health unit. A resident was seen walking from one wing to another during the outbreak with no staff intervention.

Sources: A resident's clinical records, a Critical Incident Report, Public Health Ontario (Infection Prevention and Control for Long-Term Care Homes Summary of Key Principles and Best Practices, December 2020), interviews with the ED, the IPAC Lead, the ADOC and the DOC.
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WRITTEN NOTIFICATION: Dealing With Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a resident made multiple verbal complaints to the Director of Care (DOC) related to staff members talking in a language they could not understand when providing care and made them uncomfortable, there was no investigation completed or a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

Sources: Interviews with a resident, the DOC and the Executive Director.
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WRITTEN NOTIFICATION: Administration of Drugs

NC #009 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 a resident was administered their prescribed treatment by a Registered Nurse in accordance with the directions for use specified

by the prescriber.

Sources: Home's video recording and interview with the Assistant Director of Care.
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WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (a)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(a) where the administration involves the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is authorized to administer the drug by virtue of a health profession Act, the Regulated Health Professions Act, 1991 or any relevant regulation; or

The licensee has failed to ensure that a resident was administered their oral prescribed controlled substance by a Registered Nurse, instead of Personal Support Worker (PSW).

Sources: Resident's clinical records, home's video recording, interviews with two PSWs, a PSW Student and the Assistant Director of Care.
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WRITTEN NOTIFICATION: Administration of Drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (i)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,

(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(i) a member of a regulated health profession and is acting within their scope of practice,

The licensee has failed to ensure that a resident was administered their oral prescribed drug by a Registered Nurse, instead of Personal Support Worker (PSW) Student.

Sources: Resident's clinical records, home's video recording, interviews with two PSWs, a PSW Student, and the Assistant Director of Care.

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